R.N.

ARCH - 1952

When Marian's gob came to call,

Her hands caused his ardor to pall!

So she signaled distress...

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And she's joining the Navy come fall!

● Pacquins Hand Cream was first made for doctors and nurses who give their hands so many scrubbings each day! Now Pacquins is used by more women than any other hand cream! For extra-dry skin, red label Pacquins — contains lanolin.

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R.N. CONTENTS • March • 1952

Vol. 15
No. 6

COVER CREDITS: Photographer: Walter Herstatt; Cap and pin: Simmons College School of Nursing, Boston, Mass.

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let's meet R.N. authors

You may recall **Margaret F. Howe's** "The Shoemaker's Children" in our March, 1950, issue. We like her way with the familiar essay—would like your opinion after you read this second article. Married to a surgeon whom she met in chemistry lab at Northwestern University, "thereby proving the value of science courses for girls," she has four children, loves to write.

Charlotte Kerr has worked in nursing education since 1936, when she completed her training at Presbyterian Hospital, New York City. With a B.A. from Oberlin College, an M.A. from Simmons, she's well equipped for her present job with the U.S. Public Health Service as Nursing Education Consultant to Panama under the State Department's Point Four program. Miss Kerr's "Thumbnail Thesaurus" was evolved during the years she was engaged in nursing education in Honolulu, Hawaii; San Juan, Puerto Rico; New Orleans, La.; and with the Public Health Service, under which her pre-Panama assignment was at Freedman's Hospital, Washington, D.C. She discovered that the correct use and interpretation of words was a constant source of difficulty in her work with student and graduate nurses—felt that a small section on semantics might help many nurses achieve a better understanding of the real meaning of the many confusing terms which are becoming an integral (see page 49) part of nursing terminology.

before you move . . .

please let us know your present and future address (including zone number) so we can send you your regular copies of R.N. It takes **four weeks** to correct an address and the post office will not forward magazines unless you send postage. Avoid this extra expense and missing copies by dropping a postcard to

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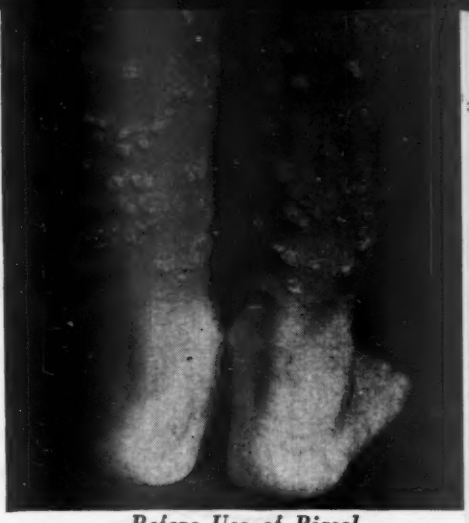
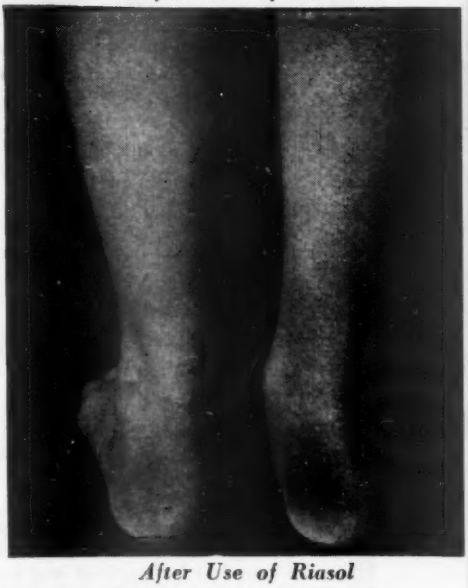


Before Use of Riasol



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DEBITS & CREDITS

A PROTAGONIST

Dear Editor:

I read your editorial, "How Golden Are Our Promises?" in the September, 1951 issue and I was deeply impressed. The facts you brought out are timely and to the point. I hope every nurse has an opportunity to read it and give it thought. What have nurses been trained for in the past 50 years if it was not for the purpose of caring for the sick and injured? When we attempt to raise all nurses to a "degree" level, we eliminate many girls who would make good bedside nurses. If nurses wish to advance after their basic training, more power to them. They can still learn—on an individual basis. Let's get the pendulum back on an even, balanced stroke.

LAURA C. FOLLIN, R.N.
SAN DIEGO, CALIF.

HE KNEW NOT

Dear Editor:

In your November, 1951 issue you published a report of the American Hospital Association convention held in St. Louis in September ("Cure for Nursing Headaches?"). In the report, under the discussion of federal aid to nursing education, you quoted a delegate as follows: "The state of Minnesota is offering $150,000 for nursing scholarships. These scholarships are going begging." This delegate, apparently, did not possess correct information.

Actually, the scholarship aid program passed by the state legislature provides $70,000 for student nurse scholarships (including practical nurse students) for the fiscal year ending July 1, 1952, and the same amount for the following fiscal year. Through the efforts of the state medical association, the bill was amended before passage so that it now includes the stipulation that one-third of this amount must be set aside for students enrolled in schools of nursing outside Minneapolis, St. Paul and Duluth. This was to overcome the "shortage" of nursing personnel in the rural areas of Minnesota. As a result, by November 20th, 160 scholarships had been awarded and only $11,734 remained in the scholarship fund. And because of the greater demand for aid from students enrolled in schools in Minneapolis, St. Paul and Duluth, the money set aside for these students was completely used up.

It is interesting to note that 177 more professional nursing students were admitted in 1951 than in 1950. While other factors undoubtedly influenced this increase, it does seem

safe to assume that the availability of scholarship aid was partially responsible. Would that we really did have $150,000 for scholarship aid. It would not go begging.

RAGNA GYNILD, R.N., EX. SEC.
MINNESOTA NURSES ASSOCIATION
ST. PAUL, MINN.

VETS OF WWI

Dear Editor:

Today's volatile world situation reminds me of my own experiences when I was an enrolled volunteer American Red Cross nurse ready for emergency calls before World War I. We expected fires, floods or other catastrophes, but in 1914 we got a world war.

The Red Cross hastily recruited units of personnel to serve overseas, and since it maintained a neutral status, we were expected to go wherever sent; we had no choice as to which country we would serve in. My own small unit from Cleveland, Ohio was delegated to serve in Budapest, Hungary. While on the ship overseas, we were given the task of learning centigrade readings for temperatures and although those of us who were seasick cared little about classes in conversion, we all studied diligently. We brushed up on the metric system too, but we had no time for language study, therefore once we started working with the Hungarians we had to depend on sign language—which we found amazingly satisfactory. I am proud of our Red Cross work in that first great war, and I should like to wish

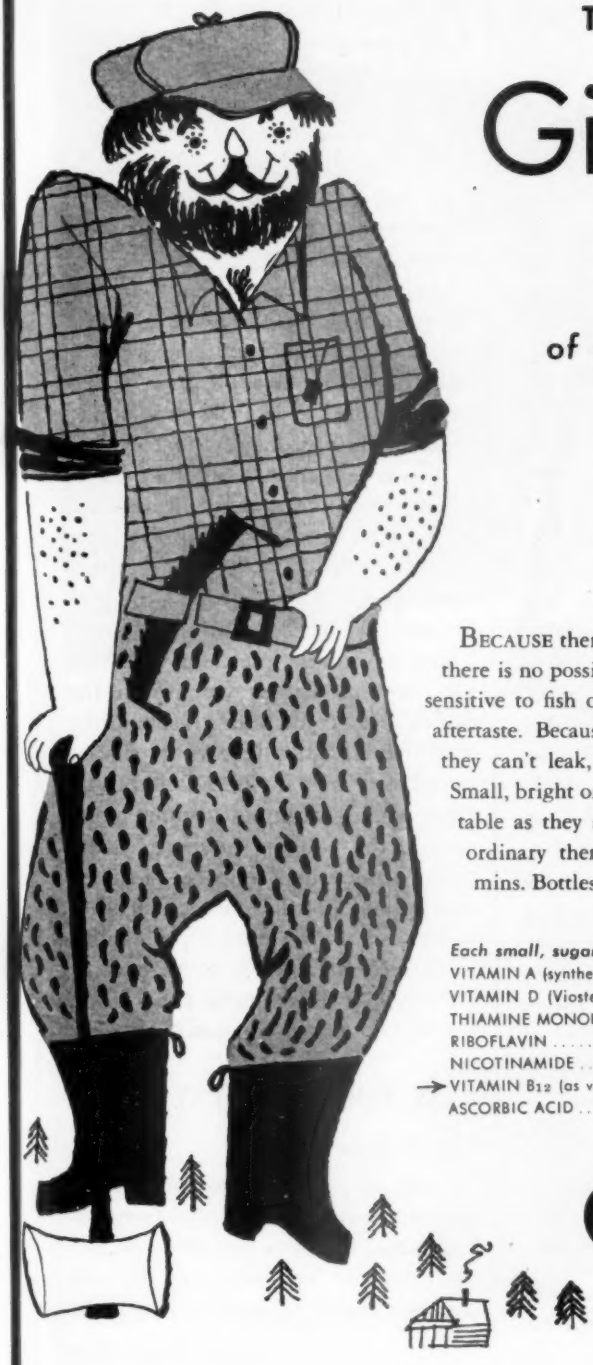
good luck to the younger generation of nurses who are serving our country today.

KATHERINE VOLK, R.N.
LOS ANGELES, CALIF.

IN OR OUT?

Dear Editor:

One of the most acute problems confronting nursing and society today is the shortage of student nurses, and the even more critical future shortage. I feel certain that recruitment personnel are doing a bang-up job in making nursing more attractive to young women all over the country. But what about young men? Everyone contacted (excepting the military brass) agrees that the male nurse has proved that he fills a vital need within the profession. Despite this, any man who enters nurses' training today is almost stigmatized as a result. One wonders that any men enter a profession which sometimes seems barely to tolerate them. If recruitment publicity would include an appeal to the males of the country, if a barrage of educational material would be released to the public to undo the stereotype that nursing is a woman's profession, if nursing schools all over the country would open their facilities to the male student, think of the many thousands of young men who would be attracted into the ranks. Think also of the desirable effect upon the prospective girl student who is torn between choosing the sterile life of a student nurse or entering a more exciting co-educational in-



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stitution. (Does not Dr. E. Lucile Brown mention this in her famous report?) I know that in various localities much has been done to advance the professional status of the male nurse, but this is only a drop in the vast bucket of untouched, unsolicited areas which still exist in the United States.

Sometimes I am convinced that most nurses think erroneously that the theme of equal military status is most important to men nurses. Certainly we should like the opportunity to have "rank" instead of "rate" within the armed forces, but that bit of bigotry does not rankle half as much as the lack of status within the profession itself. Let's stop the gumshoeing. Are we in or out of the profession? Do we belong or don't we? These are simple questions with simple answers. Either we are in the profession, contributing something worthwhile, and receiving similar benefits, or we are out. Is it fair to allow us to continue groping along outside the pale, so to speak, being made a minority group by virtue of apathy and inertia among the other members of the same profession? Let's make it co-ed all the way.

EDWARD G. BENZ, R.N.
PHILADELPHIA, PA.

CALL FOR COURTESY

Dear Editor:

I wish to present a problem involving the personnel of hospital front office staffs. I believe practices of discourtesy and rudeness are all too common. Patients' visitors have told

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me of encountering such practices repeatedly, and it seems to me that front office personnel should be screened much more carefully than they are now. It must be remembered that the people they come in contact with are very often extremely concerned about the welfare of friends or loved ones and certainly have the right to expect a polite, if business-like, answer to their questions and problems. A hospital is not like a store, where one goes to pick and choose, but is the heart of a community, established to give help and care to the sick. Its personnel should reflect the nature of such an institution and attempt to create confidence instead of tearing it down. Are we as an organized professional group strong enough and interested enough to bring about a change for the better in the front offices of many of our hospitals?

(Mrs.) Crystal W. Collins, R.N.
CHICAGO, ILL.

[*We may be in a better position when our own manners are improved.* —THE EDITORS]

MANY MORE MATCHES

Dear Editor:

The article published in the November **R.N.** on my shoe project, the National Odd Shoe Exchange, ["Matches for Misfits"] has brought much response. Thank you for making this service known to those so much in need of it.

Ruth C. Rubin
SANTA MONICA, CALIF.

5 out of 6 gynecologists approve tampons, like Meds, for normal women

. . . according to a recent national survey made by the Johnson & Johnson Research Foundation of 900 leading gynecologists and obstetricians.

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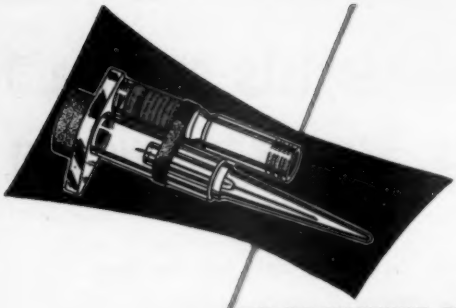

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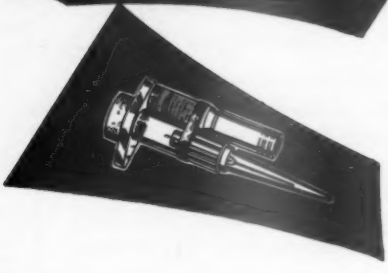

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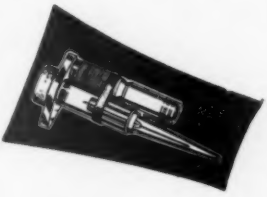

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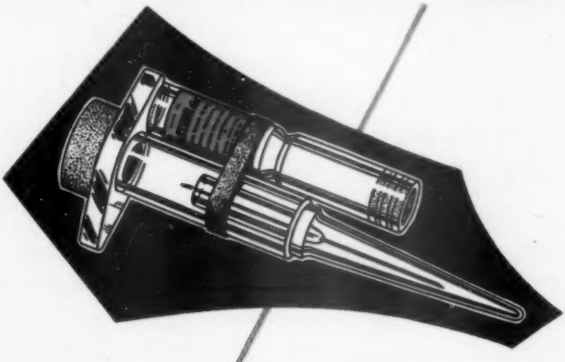

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PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

Pioneers . . .

CLARA BARTON

In selfless devotion to the wounded during the Civil War, none was more zealous than Clara Barton. Her forebears were pioneers who settled in New England prior to 1640, fought at Bennington and were followers of "mad" Anthony Wayne. At 11, she was an accomplished nurse within her own family. At 15, she taught in Massachusetts schools. Physical breakdown compelled her to give up teaching. She was an office clerk in Washington for a time. Finally, in 1861, when Massachusetts troops were attacked by mobs as they were proceeding through Baltimore to the defense of Washington, she found her life work. From then on she appeared on the battlefields—Antietam, Harper's Ferry, Fredericksburg—ministering to the wounded and the sick. When the war was over, she spent 4 years aiding relatives to trace the missing and the dead. Hospital, military, and public health nursing owes much to this intrepid pioneer.

The pioneer spirit is alive today in many branches of the medical profession, particularly in research at Lederle Laboratories in Pearl River, New York. Here, and elsewhere, the largest group of medical investigators associated with any industrial organization in the world has been gathered together. Almost every field of medicine is the subject of its research. A vaccine against canine rabies, one of the most dreaded of diseases, has been perfected. It represents a modified strain of the virus that has been grown in chick embryos. Not only has this proven a safe and effective vaccine for the immunization of dogs, but it gives such promise for the future control of rabies that it may finally reduce this disease to a menace of insignificant proportions.

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SCIENCE SHORTS

Papers presented at a meeting of the Society for Clinical and Experimental Hypnosis demonstrated that hypnotism is an important adjunct in the treatment of ailments that are chiefly emotional in origin. According to the authorities, the possibilities of hypnosis have been explored in internal medicine, surgery, obstetrics, gynecology, anesthesiology and dentistry. One psychiatrist noted that hypnotism was a valuable diagnostic tool in helping to determine whether an illness stemmed from physical or emotional causes. Special emphasis was placed on the fact that because of the dangers involved, only medical experts in the field should attempt hypnosis, and even they should proceed with caution.

*

The National Tuberculosis Association reports that the death rate from TB among American Indians is seven to eight times as high as among white people.

*

A new process whereby blood plasma can be irradiated without causing the destruction of the albumin fraction while destroying the jaundice virus was revealed at the annual convention of the American Pharmaceutical Association. In methods developed by Drs. John H. Hink and Frederick F. Johnson, a small amount of sodium caprylate dissolved in the plasma before irradiation serves to guard against the destruction of albumin.

*

A highly purified form of crystalline trypsin, a natural digestive enzyme, has been used with success in the first non-surgical treatment of tuberculosis empyema in studies at the Ohio University College of Medicine, reports the American College of Surgeons. The enzyme is injected into the chest cavity where it liquifies the hardened pus and accumulated debris which can then be aspirated.

*

Vitamin P may become a promising tool in the use of more intensive x-ray therapy for cancer, and may be even more important in reducing radiation casualties in atomic attack, Dr. I. M. Arons, director of radiation therapy at Harlem Hospital, New York, reported at the convention of the Radiological Society of North America. He said the vitamin appears to have a relationship with the capillaries whose disintegration is one of the characteristics of radiation sickness.

*

Dr. Hugh T. Jones of St. Vincent's Hospital, Los Angeles, has designed a new type of folding bed chair

which will permit a recuperating patient to sit upright in a hospital bed without the effort entailed in moving out of bed and onto a chair.

*

Laws favoring the substitution of some form of antibiotic, usually penicillin, for silver nitrate prophylaxis in the eyes of the newborn would at this time be premature, the *JAMA* stated in a recent editorial. Of the 48 states and the District of Columbia, 32 specify in the state regulations the use of silver nitrate; only one permits penicillin as an alternate procedure. Objections to penicillin include the fact that it tends to become inactive unless properly preserved and renewed.

*

Donald A. Dukelow, M.D. and Fred V. Hein, Ph.D., consultants to the AMA Bureau of Health Education, point out in Today's Health *that competitive athletic leagues are undesirable for children in the first nine grades. The doctors state that interscholastic leagues should be confined to senior high schools.*

*

In a *JAMA* report on the recovery of Chicago's "frozen" woman whose body temperature had dropped lower than believed ever before recorded in medical history, Dr. Harold Laufman, Michael Reese Hospital, Chicago, pointed out that many conclusions reached in previous studies of frostbite and milder degrees of cold exposure do not apply to the severer types, and that much more intensive animal experimentation of the more extreme types is needed.

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R.N. SPEAKS: HOW MUCH

■ LAST MONTH we pointed out the strong trend toward the creation of an architectural anomaly, figuratively speaking, that could drain the state and local resources beyond the safety point. And possibly, in time, could crush the understructure by which it is supported.

Every nurse must face the fact that the costs of carrying on nursing affairs are going up. We have long passed the point where the main reasons for holding meetings are to hear medical lectures and learn new techniques. Today our professional associations have broader functions, which include responsibility for the adequate nursing care of the community as well as the promotion of the practitioners' welfare.

Our point is this: It *does* take more membership dues to carry out the increased responsibilities of nurses, but we must consider the sound economic principle of the law of diminishing returns. How far can we go in setting dues, and how shall we spread their allocation?

In 1946, the ANA annual dues were increased from 75 cents per capita to $3.00, to help support the new programs of Economic Security, Professional Counseling and Placement Services and Public Relations. Immediately following that increase, the ANA membership dropped from 181,428 to 161,509 members. To this day its peak has only been about 176,000. As a matter of fact, in 1951 there was another 3,000 drop in membership. Present membership is about 173,000.

Yet, despite this experience, and although nurses of this country have been informed through national and state publications that the new national dues have been estimated at $5.00, a $2.00 increase over the present figure, the aggressive nurse leader from California asked in January that the ANA Advisory Council recommend dues be increased upward to $10.00. She followed the recommendation with the boast that California, with the highest dues in its history, has the largest membership, with a record of no loss of members.

What the California spokesman did not divulge to the Advisory

IS ENOUGH?

Council's 150 members was that her state is the most atypical state in the U.S.; that in a seven-year period from 1940-1947 it had absorbed three million new residents; that it was suffering from social ferment and skyrocketing costs and service charges due to its phenomenal increase in population; *that only 22 per cent of the potential nurse membership in California belongs to the CSNA.*

It has been true of all professional organizations that as national income goes up so do national activities, with an inevitable new burden of work for the local constituents. Just as inevitably, therefore, state and district dues must go up too—or breakdowns occur in carrying out the programs locally.

Another point most likely not considered by many, but of import nevertheless, is that higher dues are bound to cause some nurses to withdraw from membership. Chances are that the drops will occur most frequently in the lower income group, where opportunities for promotion are in proportion to a nurse's academic preparation. Is it the intent of a few to build an exclusive association representing more of what one of our leading nurse statesmen calls "Haves" than "Have nots"?

All these are minor arguments when compared with the impending peril of allowing a national association to become so financially strong that it can dominate and coerce, if it chooses, the emasculated state associations. It follows as the night the day that the more money collected for the national treasury, the more elaborate must be the programs provided on a national scale to justify the increase in dues. The question, "How much is enough?" is one of the perplexing problems that nurses must find the answer to soon. The other problem, to be considered next month, is how can we maintain the necessary balance of power between the state and national organizations that appears to be threatened.

—ALICE R. CLARKE, R.N., EDITOR

. . . all the world's a stage

■ MIND IF I STOP to look in on a few sick ones—take about five minutes—?" My doctor husband usually asks this about two blocks from home on evenings when we are setting out for a hockey game, or a visit with some much neglected friends, or a concert at the high school. And I never mind, for I have found that what goes on in the waiting room of our small town hospital can be fascinating. It may not be the Theatre Guild, but sometimes it comes very close to it.

By modern standards, our hospital is a rather plain one, and the waiting room is only less drab than it used to be because of the valiant struggles of the members of the Woman's Auxiliary with tan walls, high ceilings, narrow windows and bumpy furniture. Although the room is small, it boasts two davenports which face each other across a table cluttered with limp *Saturday Evening Posts* and out-dated *Lifes*, and two chairs in the corners which is where you must sit if you intend to read since that is where the lamps are. By way of decoration, there are some gay draperies and a poster beseeching YOU to enter a nursing school. In one of the unlighted corners is the chair I claim as my own if no one else has preceded me. And beside this is the telephone booth from which the news of the births, deaths and the crises of the community goes forth to ones who care.

Despite its drabness, there is in this small waiting room an intimacy and coziness free of any pretense of sophistication, and there is in our town something of the same disregard for formalities and the friend-

by Margaret F. Howe

liness which invites the scenes which unfold there. It is a rare person who does not at some time of his life know this room well.

Of course, there are those evenings when nothing happens. We all sit, holding our old *Posts*, and waiting for the first act, but the Muse isn't working. And then there are some evenings when I wish I had stayed in the car. These are the times the malcontents enjoy a gripe session. They start with the hospital administrator and end up with the cleaning women. They don't like the new three-toned walls; the nurses talk so loud at night Grandma can't get a wink of sleep; the aides never answer the lights and leave the patients on the you-know-what for hours; and the cleaning women completely overlook the fuzzies under the dressers. What really takes me eagerly back to the room everytime my husband wants "to look in on a few sick ones" is the memory of people like Fred, and Minnie, and Mr. Milquetoast's brother, and the Woman of the Good Heart, and the possibility that I'll meet more like them.

Let me tell you about them: Minnie and Harriett were two birdlike sisters from an outlying town who, entirely resigned to their father's imminent passing, sat on the davenport opposite me, making their plans for the funeral which would surely take place within the week. In their intensity over the details, they were utterly oblivious of me in my dark corner. They agreed as to which relatives should rate telephone calls or telegrams, and which would be content with letters. Minnie's black dress was still good, and Harriett thought her suit would do. They would ask that flowers be omitted and contributions sent to the church fund. But

when it came to the selection of an undertaker, an impasse was reached. There are several in this area, and to the casual eye they are of equal efficiency and ability. But Harriett wanted Smith and Minnie wanted Jones.

Harriett pointed out that Smith had laid their mother out beautifully, and felt it would be a slap in Smith's face to ask Jones to take care of Father. Minnie hedged but advanced the doubtful point that the mayor had recently been done by Jones. Harriett didn't allow the point. She didn't see what that had to do with Father. Finally Minnie sighed, put her head on one side, and blushing the dark rose blush of the aged, she said, "Well, Harriett, I guess there is something I ought to tell you. You may have to take care of me—I'm older'n you, and you really ought to know about this anyway. But—well—there was something between Kellan Smith and me—a long time ago—we were just girls then. Then he met Hilda Weller, and her husband had left her pretty well fixed, and of course, I always thought he married her for her money—that's what any jilted woman likes to think, you know. He seemed sort of ashamed, because he never spoke to me after he married her. He'd cross the street—pretend he saw somebody comin'—if he spied me. Well, he done it once too often. I was walking with Wilma Horton—the minister's wife, you remember—and he comes along and says, lifting his hat, 'Nice to see you, Mrs. Horton' and never looks my way. I thought to myself then—'Well, all right, Mr. Kellan J. Smith, if you don't know me alive, I'll see to it you won't know me dead' and I marched right across the street to Joneses' parlor, and picked me out a nice casket, not expensive, but nice—you won't be ashamed of it—and I paid him for a funeral. The receipt's in my locked box, where you'd a found it when I—when I'm gone. You see, Harriett, I can't have Smith do Father."

Harriett's chin wavered, "Oh, Minnie—oh my goodness, Minnie." I slipped out of the room, but as I was leaving, I heard her say "My poor Minnie—of course you can't."

One night in hunting season my husband was called for an emergency, just as we were leaving for a meeting. "Come along—you can wait at the hospital," he called, and I was on my way. As I turned toward my chair the odors of wood smoke, crisp cold outdoors, tobacco and wool met my nose. The room was full of masculinity, and a group of hunters sat, stood, and draped themselves about, their hunting-camp attitudes still with them. I selected my magazine, found my chair, and soon realized that they had brought Charley in from the next camp. Charley, it seemed, had gotten a bullet in his thigh, but he wasn't getting much sympathy from his fellow sportsmen.

"Damn fool" said a big fellow with bushy hair, as he lighted a pipe. He continued to talk around the pipe in staccato fashion—"See him at the Straits? He was five, six, cars ahead of Bill and me—cars backed up near to Sheboygan—musta been 12, 14

miles. Ferries was running wild at the Straits. Well, this Charley was alone—meeting his party up here, and he gets bored. He has a bottle and he doesn't spare it I guess."

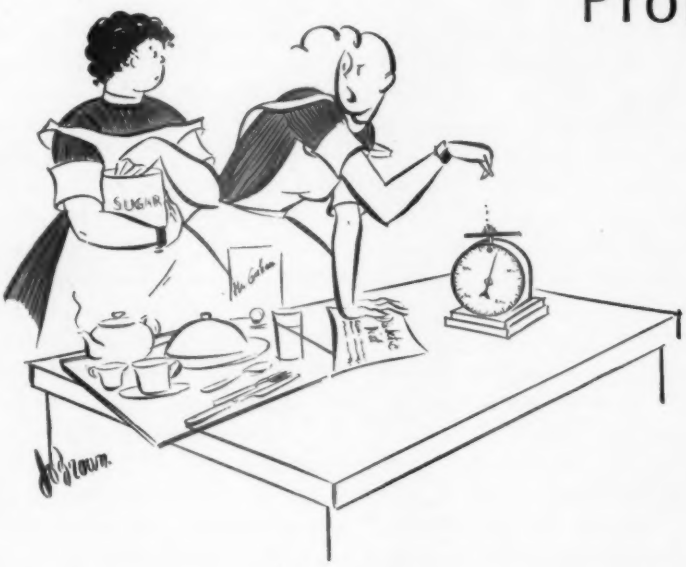
Another fellow adjusting his boots, growled, "That wait at the Straits would make Carrie Nation take to drink. I waited 23 hours last year. You don't dare leave your car to get coffee even—never know when they're going to move up."

"Well, Charley left. That was the trouble. And when he comes back, the line had moved around him. He had had enough to drink, so he gets mad, and goes and drags the fellow in the car ahead of him out and starts swinging. All the guys in the other cars jump out, glad enough for something to keep their minds off the waiting, and in about five minutes it looked like Old Home Week in Madison Square Garden."

An older man sitting on the davenport put in "Fellow from Big Buck Camp says he met this Charley out along the ridge back of camp first morning, and he's all in duck hunting clothes, and this fellow says, 'Hell, I almost shot you—don't you know enough to wear reds in the deer woods?' and Charley gives off with how many hunters got wounded last year, and all of them wore reds, and he says he hunted 16 years in browns and that's what he's going to keep on hunting in."

A little fellow with glasses whistled, solemn faced. "Browns—in the deer woods. Holy Dan'l Boone!" There was a dumfounded silence

Probie



"Well—don't stand there—give me one more grain."

while they contemplated the temerity of a man who would go into the deer woods in browns. I had a feeling that part of their amazement was not so much at the disregard for personal safety but at the defiance of male convention. Charley might as well have gone to the Bachelors' and Benedicts' Ball in tweeds.

"Well I'll be damned," said the man with the bushy hair, as he got up. "I'm not sitting around any hospital wringin' my hands over any guy dumb enough to go into the deer woods in browns. Come on fellows, the drinks are on me." To a man, they arose, their heavy soled boots loudly stumping on the concrete floors, and pulling their snug hunting caps over their ears, they passed through the swinging doors and out into the cold, sparse, early snow.

One rather unpromising night I sat in my corner wishing I had stayed at home to do my waiting. A father-to-be sat uncomfortably on one of the davenports. He wasn't pacing the floor, but he certainly paced that davenport. Two Indians sat huddled on the other, saying nothing, with the mute apology of the minorities in their eyes. Into our silent midst came a small mild man who might have been Mr. Milquetoast's younger brother. He looked from one to another of us, then inquired meekly "Excuse me—would anyone mind if I use the telephone?" We assured him we wouldn't, and he stepped into the booth, nodding at us with an apologetic smile as he disappeared into its depths, and called a downstate city. After a short wait, he began to speak quietly . . .

"Hello, Bess." The booth was poorly sound-proofed, and every word was all too plain. "Bessie, this is Horace—yes, no—nothing's happened Bessie—no—she's all right—No, Bessie, I told you, *everything's* all right—no she's *not* worse—well gosh, Bessie, I didn't mean to scare you; you said to let you know. Well, I'm awful sorry I called, Bessie, but now I did I might as well tell you, she's a lot better—no she hasn't got any fever—yes she ate some soup for supper—no that's not all she ate—listen, and I'll tell you—what's that—no, she can't, the doctor says she can't make no such trip—she's all right here, Bessie. He isn't either a backwoods doctor, Bessie, he's a good doctor.—And she *isn't* all alone up here in the woods—*I'm* here, aren't I.—And I'm takin' good care of her. I been her husband fourteen years." His voice rose in desperation, "You think you're the only person on earth knows anything, and you don't, see. She's stayin' right here in this hospital, and she's havin' the same doctor—and *I'm* sayin' what she does after this. I'm sick of you, and your whole family." He slammed the receiver, and flung open the door, then, startled to see us whom he had forgotten, he planted his feet firmly, and announced, "I hate that woman. I hate her," and turned to march out of the door and down the hall.

By far the nicest evening I spent at the hospital was in the company of Fred, the Woman of the Good Heart, Russell, and a Frenchman called McNab. [*Continued on page* 60]

Fashion Notes for nurses by Francie Hughes

RN SPRING CHECK-UP OKAYS REVERSIBLE PENDULUM-COATS

• Wear one of Judy Nell's cheery checked coats and you won't need a robin to tell the world it's Spring. You'll cheer too because they reverse from the sporty checked wool to the dressy ottoman side to give you two coats for the price of one. 34" topper, $35; full length, under $40.

SUITS THAT SUPPLY THEIR OWN HATS . . .

● **Collect your Spring bonus: an enchanting Judy Nell suit complete with its own becoming, matching hat for $25. R.N.'s who can wear full skirts, nipped waists, padded hips, will like the shoe-buttoned checked suit and demi-brimmed hat (left). Dressier choice is the ottoman suit (right) with velvet collar, straight skirt and winged profile hat.**

Write makers (names and addresses on page 94) for stores carrying items on all fashion pages.

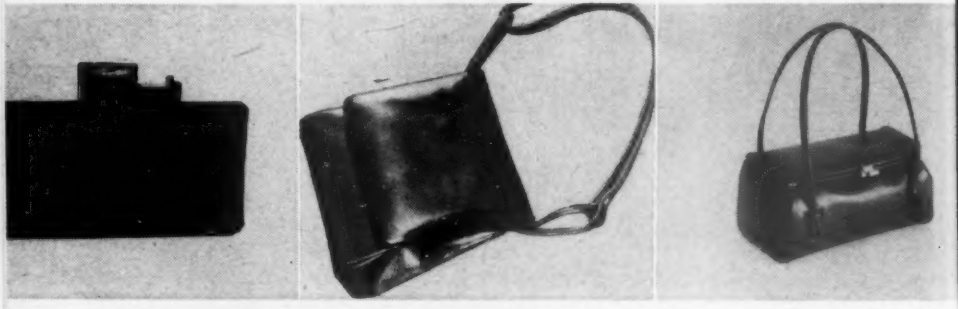
● Find a coat that's chameleon enough to go over everything . . . that manages to look as smart and correct in town as it is casual and comfortable in the country . . . that doesn't cost a fortune... and what have you got? A Lassie Maid. Taffeta-collared checked wool tweed, $49.95; sunburst-seamed wool fleece, $45. (Topper-lengths for $5 less).

COATS WITH A CITY-COUNTRY AIR

Shop Talk

● HATS for Spring are mostly small . . . straight, not tilted (except for profile hats) and gay with color, ribbons, flowers, veils, jewels, sparklers. Good examples: Schacter's sailor, left, with tasseled veil; Helen Joyce's flower-filled roller, center; Brandt's jewel-studded straw bonnet.

BAGS for Spring can be big or little and these three—smart, beautiful and loaded with value—will give you your choice. Edward's faille Lipstick Bag has a sensational lock that holds a lipstick, while the pop-up top becomes a mirror, $7.95*; Companion's capacious calf shoulder-bag has zipper-hideaways and an adjustable strap. $10.95*; Margolin's shiny calf box bag has a mirrored lid and arched handles, $10.50*. (*Plus federal tax)



SHOES for Spring are newsy, light, graceful—true, even of those with low or mid-high heels. Somersworth's Citation, left, a suit-shoe, has a new free-form tongue garnished with white piping, $5; Lucky Stride's instep-tie has the new LOW heel with the HIGH heel-shaping, combining real cobra with a dyeable linen vamp, $10; Rondeau's Butterfly, one of the new CORSET shoes, slips on like a breeze, adjusts without buckles, $5.

CAN DID COMMENTS—

Turn your worry into work

■ SOME MONTHS AGO three nurses came to visit to describe a serious personnel practices situation. "We know that the best way to handle this is to get district action," said they. "But we can't get to first base there. The officers, directors, and many of the committee people are inexperienced, rather cocky nurses who seem to think that nothing happened yesterday—everything began the day they were elected. They want no advice from experienced people. All the mistakes have to be made over again! They don't *see* our kind of problem. There's no use to expect action from them."

I advised, "Then why not get a better mixture on your board? I've always believed that we're in the best position when the board represents both maturity and youth. You'll have an election soon. Stir up interest in giving your Nominating Committee a chance to present a representative ticket. How does your Nominating Committee work? Well, you can find out. A strong board doesn't just happen. You have to work for it. The benefits will reach beyond you to all your members and to the profession itself."

We spent quite a bit of time discussing simple parliamentary principles and the rights and duties of members. Recently, I met one of the nurses—and I asked about the election—and were they getting action in their problem? The nurse was startled—then she laughed in embarrassment. "Honestly, we clean forgot about it," she confessed. "You see, I got a better job. Clare quit hers to go to school, and Marie got married."

This isn't an imaginary tale: it happened—and it happens again and again in varied patterns. These nurses had legitimate grievances that related to a large group of nurses. Any improvement would have helped the individuals and the profession as well. These three nurses were very sure of the practices they didn't want —but not nearly so sure of those they did want—except Sundays off and more pay. They had no idea, in seeking advice, of the power for remedial action that was inherent in their own rights and duties. When they learned it, they lost interest and quit the difficult jobs. Actually, their purpose in asking advice was to unload their gripes on the shoulders of someone they hoped would take up the battle for them.

"God helps those who help them-

by Janet M. Geister, R.N.

selves," is pretty sound philosophy. Our health departments, for example, work constantly to protect our milk, water and food supplies. They provide immunizations against certain communicable diseases—and similar assistance in preventing other diseases, and in promoting health. Public health nurses go out to help families apply these protections in home and family life. They teach simple hygienic and health principles. The whole program must be effective in the lives of people if it is to bring results. But unless the families in their homes, and people generally, work *with* the nurse and health department, not only does the family lose, but so also do the neighbors and community. To be helped, people have to help themselves.

Our professional associations work equally hard to provide help to the individual as well as to the profession and, through them, to the community. Year after year committees constantly work to improve the district, state and national by-laws to strengthen the power for action. Every possible safeguard is thrown around the elections and conduct of business in order to give all individual members equal opportunity. When individuals do not know their powers or are indifferent to them, it's only natural that others, more alert, use these powers for them. "If you know your parliamentary law," remarked one nurse who had just scored a victory in a surprise vote, "you can get away with anything." What she meant was if *you* know your laws and the others in your particular association do not know them.

We may know the methods, however, and still be of little help if we've progressed only to the point of being against things. It takes maturity and a sense of professional responsibility to be against things *only* to be for something better. Griping is a luxury we can afford only if it's an outlet, not an excuse. A lot of people are highly vocal about things that are wrong, but confused and inarticulate about the constructive things that should be substituted. It seems to me the world is over-full of people today hunting for shoulders to cry on. They greatly outnumber those who roll up their sleeves and who use their eyes for a more useful purpose than tears. Simply doing away with wrong conditions of people can be worse than no action at all, if we aren't ready to put something better in their place. In World War I, our country, with others, rose against a power-hungry dictator. We eliminated this dictator only to make room for two more (and another war) because the vacuum created by this elimination was not filled with something better.

The obligation to think and plan lies as much with the members as with the leaders we elect to office. Indeed, the very future of the profession depends upon the ability of the majority to reconcile differences in opinion and join hands in support of what they want. Never has there been such a conglomeration of opinions among us as today. In the past, our road was fairly well rutted; today, we are cutting out a brand new

way. We have, as a result, two schools of thought diametrically opposed, and between them a larger middle-of-the-road group which sees some virtue in both points of view. Some nurses have absolutely no use for the non-professional nurse in any capacity; others concede that she has a place in the home, but not in the hospital, and vice versa.

And there are the extremists who believe the professional nurse's main function is supervisory—that various grades of other kinds of nurses (non-professional) will have the main person-to-person contact with the patient. We hear one leader state that the nursing of the future will be "through" others. We learn of another who states that the "patient's comfort" will not be our main concern—that we will work through "communications," which I believe is another way of saying nurses will reach patients through others. It's hard to determine what this means in terms of the professional nurses' personal services to patients. I have long recognized the need for helpers in nursing jobs who can take over the tasks that do not require professional nursing. But my conviction is strong that any marked separation in the personal relationships between the patient and his doctor and nurse disturbs a *natural* situation. The doctor once used his ears, eyes, finger tips and intuition in diagnosing. With the advances of science, more dependence was placed on the x-ray and test tube—and, said Dr. Walter C. Alvarez, Mayo Clinic, Rochester, Minn., to a medical convention, "Mistakes are being made even in the practices of able specialists, because diagnosing with the ears and eyes is becoming a lost art," . . . doctors are running risks in depending on x-ray departments and laboratory reports "because they feel they are too busy themselves to take a personal history."*

Nursing runs a risk of similar losses when education and practice move too far from our central interest—the patient. *Time* magazine (October 1, 1951) reports a new development in medical education: "Students used to spend two years in medical school before they ever saw a patient . . . At the nation's newest medical school, at the University of California at Los Angeles . . . first-year men will begin learning from patients in their first week . . . Dean Warren never tires of saying, 'The doctor exists for the patient'." These things indicate that when we get too far off center in our "advances" we either fall short in our work or the pendulum must return to a more natural center. This holds true both in nursing education and practice.

The growing gulf between our two schools of thought today can become very serious to our professional solidarity—and without a certain degree of agreement on our major objectives and programs we will move in every direction but forward. We cannot settle this or any other question presenting marked disagreements simply by being against new departures. If we have examined the new proposals and find [*Continued on page* 72]

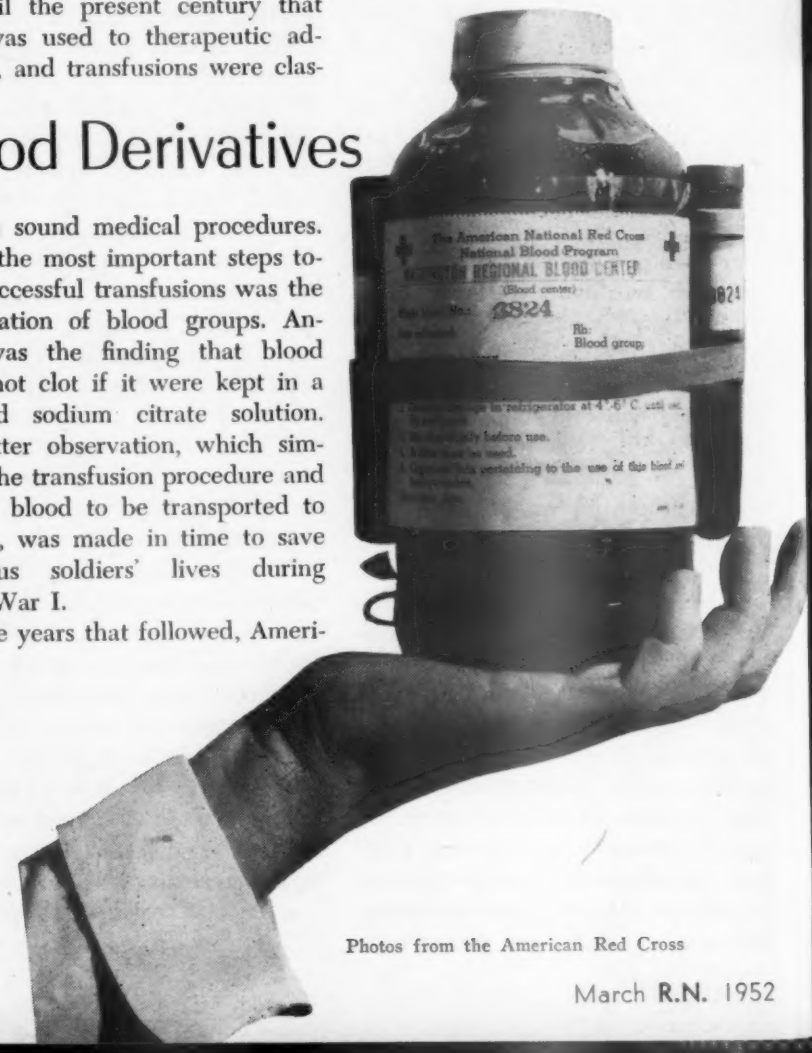
*N. Y. *Times*, July 27, 1951.

Blood Derivatives

■ TO THE MAN on the fighting front or the civilian in the comparative safety of his homeland, the availability of whole blood and its derivatives offers a miraculous means of saving and sustaining life.

At various times in our history, and particularly after the discovery of the circulation of the blood in 1628, transfusions of blood were attempted, but more often than not proved ineffective or fatal. It was not until the present century that blood was used to therapeutic advantage, and transfusions were classified as sound medical procedures. One of the most important steps toward successful transfusions was the identification of blood groups. Another was the finding that blood would not clot if it were kept in a sterilized sodium citrate solution. This latter observation, which simplified the transfusion procedure and allowed blood to be transported to patients, was made in time to save numerous soldiers' lives during World War I.

In the years that followed, Americans have witnessed the nationwide development of blood banks, and the organized efforts to supply blood and plasma to the armed forces during World War II and the recent conflict in Korea. The medical world has recognized the efficacy of plasma and serum in combating shock; the importance of the Rh factor and other blood factors; and the therapeutic value of blood proteins obtained from the fractionation of



Photos from the American Red Cross

and Plasma Substitutes

by Frances Lewis, R.N.

plasma. It has also given its nod of approval to many other technical discoveries of less dramatic import. And still the studies go on—for blood has not yielded all of its secrets, and scientists have yet to find an adequate synthetic substitute for this life-giving fluid.

But even though there are no substitutes for blood, certain components of blood exhibit properties which make them particularly useful in situations where blood cannot be readily obtained, or where it is not definitely indicated. Plasma, of course, is the most important blood derivative and from it can be isolated proteins which act as valuable medicines. One of these proteins, serum albumin, is employed in the treatment of shock and nephrosis and appears helpful in malnutrition and cirrhosis. Because of its antibody content, another, gamma globulin, helps to prevent measles or make the disease milder; it may further protect against mumps and infectious hepatitis and possibly other infectious diseases (see **R.N.**, February, 1951, *Drug Digest*). A third protein, fibrinogen, may be used locally as a fibrin sponge to control bleeding from wounds or surgery, and a solution of thrombin, also obtained from blood, helps the clotting process along. An additional blood component, the anti-hemophilic globulin, though difficult to obtain, is reported to speed up the abnormally slow clotting time exhibited by victims of hemophilia.

Of all the blood derivatives plasma is obviously the most complete and, while it cannot do all the things that whole blood does, may be used to replace blood in those conditions

which do not require the administration of the cellular elements. Thus plasma may be therapeutically effective in hypoproteinemia, hemophilia, certain infectious diseases, and shock without severe blood loss, but will be inadequate in anemia or massive hemorrhages which call for replenishment of erythrocytes.

Plasma and whole blood are especially effective in the treatment of shock because the plasma proteins, particularly the albumin protein, help to retain the transfused fluid in the vascular system. Plasma proteins, it may be remembered, do not escape through the capillary walls as easily as do the smaller molecules contained in crystalline solutions such as dextrose or sodium chloride solutions. It has been stated that 1 Gm. of plasma proteins holds about 18 cc. of water in the capillaries, and that albumin exerts approximately 85 per cent of the oncotic pressure provided by the plasma proteins.[1] It is easy to see then why the albumin fraction of plasma may be used in nephrosis, a disease characterized by an abnormally low plasma albumin and marked edema.

The main indication for the use of plasma, however, is in "hematogenic shock" resulting from loss of whole blood or plasma. Although medical authorities differ over the physiological sequence of events in shock, the condition itself may be described as a syndrome resulting from circulatory failure; the most characteristic signs of which are pallor, cold moist skin, rapid, weak pulse and lowered blood pressure. Since the circulatory blood volume must be restored in order that the blood may perform its vital function of supplying oxygen and food to the tissues and organs, transfusions of whole blood or plasma are definitely indicated in this type of shock. It should be emphasized that transfusions are not needed in the "neurogenic shock" resulting from pain, spinal anesthesia or exhaustion; nor are they helpful in "cardiogenic shock" caused by sudden heart failure. In the latter form of shock, transfusions may be contra-indicated since they put an additional strain on a failing heart.

Clinicians agree that prevention is more important than diagnosis in "hematogenic shock."[2] One must initiate intravenous fluid therapy in wounds, fractures, hemorrhages or burns before the classical signs of shock appear; if treatment is delayed, circulatory failure may become irreversible and fail to respond to any type of therapy. Investigators have variously attributed irreversible shock to irreparable damage of vital tissues from lack of oxygen, generalized capillary damage, and accumulations of toxic products in the body.

Should plasma or blood be used to restore the circulatory blood volume in "hematogenic shock"? On this question the AMA Council on Pharmacy and Chemistry says: "whole blood always is preferred over plasma or serum when shock is complicated by hemorrhage or severe traumatic injury which results in a loss of functioning blood cells."[3] Transfusions of whole blood, accord-

ing to Drs. Strumia and McGraw, are needed on an emergency basis only by patients whose state of shock is caused by severe hemorrhage "that continues at the time of treatment."[4] These two doctors point out, however, that in all cases plasma may be used as a "temporary life-saving measure" until whole blood can be made available. Furthermore, when hemoconcentration is present, as in burns, where fluid rather than red cells escape the body tissues, plasma is definitely preferable to whole blood.

From a practical standpoint, plasma has certain advantages over whole blood. It can be preserved for long periods of time in the frozen or dried state; it is easier to store and distribute than whole blood; and, in general, can be given without causing untoward reactions. Although hospitals usually have enough blood for emergency use, and maintain a supply of group O, Rh negative blood for this purpose, certain situations may arise in which the proper type of blood is not available. It is in these instances that plasma, which can be given without regard for the patient's blood group, is so valuable.

It should not be assumed that plasma is entirely free of side effects, but if properly prepared, it should be relatively safe. According to the method described in the *U.S. Pharmacopeia,* whole blood is obtained from eight or more persons who have been declared free of a transmissible disease. Under aseptic conditions, each bleeding is drawn into individual sterile centrifuge bottles containing sodium citrate solution. After the plasma is separated from the cells, it is transferred to a poo. by means of a closed system. After sterility tests, the plasma is placed in its final containers—again through a closed system. The pooling of several lots of plasma results in a dilution and lowering of the agglutinin content, and reduces to a minimum the chances of producing agglutinin reactions. Properly pooled plasma can therefore be used without regard for the patient's blood group. Pooling also lessens the danger of contamination, for cultures may be taken from the pooled plasma rather than from each lot. To reduce the danger of transmitting the virus of serum hepatitis, pooled plasma is now treated with ultraviolet radiation. There is almost no chance of recipients contracting malaria or syphilis from plasma. Though they occur infrequently, the most common reactions to plasma transfusions are attributed to either pyrogenic or allergic factors.

Another valuable blood derivative, serum, is also subjected to the pooling and sterilizing process. This liquid portion of clotted blood differs from plasma in that it does not contain the clotting elements such as fibrinogen and prothrombin. Although Normal Human Serum N.F. is a less complete blood derivative than plasma, it may, as in the case of plasma, be considered a satisfactory substitute for whole blood, except in those cases where the administration of [*Continued on page* 57]

DRUG DIGEST

CITRATED NORMAL HUMAN PLASMA U.S.P.

(Blood Derivative)

PRODUCT NAMES: Normal Human Plasma (Dried), Normal Human Plasma (Citrated), Lyovac Normal Human Plasma

PHARMACOLOGY: Citrated normal human plasma, representing approximately one-half the total volume of whole blood, contains the entire liquid portion of the blood, including the protein fibrinogen. Normal human plasma must comply with National Institutes of Health requirements which include necessary examinations of donors and ultraviolet radiation of the pooled plasma. Indications for plasma therapy include surgical and traumatic shock, burns, and hypoproteinemia. Plasma may also serve as a temporary substitute for whole blood in cases of hemorrhage; however, it cannot take the place of whole blood in those conditions which require the administration of red blood corpuscles.

DOSAGE: Citrated normal human plasma can be obtained in liquid, frozen or dried forms. Dried plasma, made from frozen plasma, is restored to the original volume by mixing it with a sterile 0.1 per cent solution of citric acid in water immediately before injection. The usual intravenous dose is 500 cc.

UNTOWARD ACTIONS: Although plasma injections do not carry with them the hazards of blood transfusions, there may be some harmful side effects. Even bacteria-free plasma may produce reactions if it is used with improperly cleansed equipment. Plasma with a high hemoglobin content is also liable to result in reactions. Congestive heart failure may be caused in certain cases of cardiac weakness if plasma injections are not given slowly. There is also the possibility that homologous serum hepatitis may occur following the use of normal human plasma.

NORMAL HUMAN SERUM ALBUMIN U.S.P.

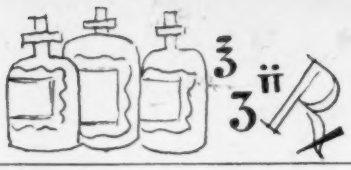
(Blood Derivative)

PRODUCT NAMES: Normal Human Serum Albumin (Salt-Poor) 25%

PHARMACOLOGY: As in the case of citrated normal human plasma, normal human serum albumin complies with the official requirements of the USPHS National Institutes of Health. Prepared by fractionation, it represents the liquid separated from clotted blood, and therefore contains no fibrinogen. Although the albumin of human plasma comprises only about 60 per cent of the plasma proteins, it nevertheless is responsible for almost 80 per cent of the osmotic efficiency of plasma. It is also stated that 100 cc. of 30 per cent albumin effects the same osmotic pressure as 1,000 cc. of whole blood. As a result of this osmotic property of bringing water into the circulation, it is used in the treatment of shock to decrease viscosity and restore the volume of circulating blood. It is also employed to reduce edema and to elevate the serum protein level in hypoproteinemia. The fact that normal human serum albumin can be packaged in concentrated form in relatively small ampuls makes it particularly useful in military situations.

DOSAGE: Normal Human Serum Albumin (Salt-Poor) 25% is available in 20 cc. bottles, each "containing 5 Gm. of albumin with not more than 0.33 per cent of sodium in a buffered diluent, osmotically equivalent to 100 cc. of plasma." About 2.2 cc. per kilogram of body weight is administered intravenously, at a rate which should not exceed 2 cc. per minute. A solution of normal saline or 5 per cent glucose is generally given with the albumin.

UNTOWARD ACTIONS: Toxic effects are relatively infrequent. The main disadvantages associated with its use are high cost of preparation and limited availability.



SPECIAL GELATINE SOLUTION, INTRAVENOUS N.N.R.

(Plasma "Substitute")

PRODUCT NAMES: Special Gelatine Solution, Intravenous 6%

PHARMACOLOGY: This preparation of refined beef bone collagen which was developed in the U.S. during World War II is classified as a pyrogen-free, non-antigenic gelatin solution in isotonic sodium chloride. Because it has a relatively high osmotic pressure, similar to that of plasma, this form of gelatin is able to draw water into the blood stream and hold it there. For this reason, I.V. injections of the hypertonic solution may be used to restore diminished blood volume in shock or circulatory collapse associated with burns or hemorrhage. Gelatin therapy is employed when plasma and whole blood are not available for emergencies or are not indicated.

DOSAGE: Special Gelatine Solution, Intravenous 6%, containing 60 mg. of gelatin in each cc., is available in 500 cc. bottles. Since 50 per cent of the gelatin stays in the circulation after 24 hours, one 500 cc. infusion generally ensures osmotic protection for 24 to 48 hours. Because this form of gelatin forms a gel at lower room temperatures, the bottle of solution must be warmed to about 50°C before administration. The solution may be given safely at rates up to 30 cc. per minute.

UNTOWARD ACTIONS: As in the case of other plasma "substittutes," care must be taken to avoid producing excessive fluid volume in cardiac impairment. Also, because it is mainly excreted by the kidney, the solution is contra-indicated in renal impairment, in the crush syndrome or in third degree burns—conditions associated with possible renal damage. Samples of blood for cross-matching or typing should be obtained before injection as the infused gelatin results in pseudo-agglutination of the red cells. A cloudy solution should never be used.

POLYVINYLPYRROLIDONE

(Plasma "Substitute")

PRODUCT NAMES: PVP

PHARMACOLOGY: Polyvinylpyrrolidone, or as it is commonly called, PVP, a derivative of acetylene gas, was first employed as an intravenous solution in Germany during World War II under the trade name of Periston. German doctors used it extensively on the battlefield as an emergency blood substitute in the treatment of burn shock, in surgery and in circulatory disturbances occurring in infectious diseases. PVP-saline solutions have also been developed in England, France and Switzerland. According to the AMA Council on Pharmacy and Chemistry, a 3 per cent solution of the substance in saline has approximately the same colloidal osmotic pressure as plasma. As yet there is insufficient clinical evidence to warrant its being officially classified as a satisfactory plasma "substitute" for shock, but preliminary studies are described as promising, and it has received limited approval for stockpiling for emergency use only. The use of PVP in prolonging the effective period of certain drugs has been under investigation.

DOSAGE: The average therapeutic dose of 3.5 per cent PVP-saline in shock and similar conditions is estimated to be 500-1,500 cc. for adults in the usual state of shock. For small children and infants, 25 cc. per kg. body weight repeated twice daily is generally given. Although PVP may be administered by all the parenteral routes, I.V. injection is the most common method. PVP has not yet been released for general medical distribution.

UNTOWARD ACTIONS: Laboratory studies on cats have indicated that large amounts of the solution may be given to replace 70 per cent of the blood volume without producing untoward effects.

WORDS AND IDEAS: It is interesting to note how the same idea emerges from time to time under a new name. It is as though an actor appeared in successive scenes in different costumes. Intrigued and bewildered by the gorgeous costume, we fail momentarily to recognize the actor beneath the clothes. We grasp avidly at these "new" ideas as though, at last, we had laid hold of something which was to prove the touchstone to our problems. Then, on closer look, we see that it is really an old familiar idea in a new dress.

Words are useful and convenient tools, but they must be regarded as tools. We are becoming so bogged down in the mere act of defining words, that we fail to accomplish positive thinking. Terminology becomes more important than thought.

Perhaps because nursing is rather new at higher education, nurses are among those most easily dazzled by words and their meanings. We hear about "interpersonal relationships" today, about the "dynamics of behavior," about the "spectrum" of nursing. It sounds very fine—very erudite. It is the vocabulary of our particular period, and proves quite satisfying until we start to analyse its original meaning; until we seek the idea beneath the words.

Then "interpersonal relationships" becomes simply the ability to get along with people. "Dynamics of behavior" means the reasons or principles underlying our acts, and the "spectrum" of nursing breaks down into the fact that there are simple, more complex, and quite complicated procedures involved in caring for the sick. One ventures to say that Florence Nightingale knew this—only she didn't call it a "spectrum."

Semantics is a fascinating subject, but let us not deceive ourselves into a sense of false security by hiding behind words themselves. *It is the ideas which words convey which are important.* Rather than ask, "Have we the right word?" let us ask "Have we the right idea?" no matter what words we take to clothe it.

by Mrs. Helen J. McAllen
Editor-in-Chief,
Davis' Nursing Survey

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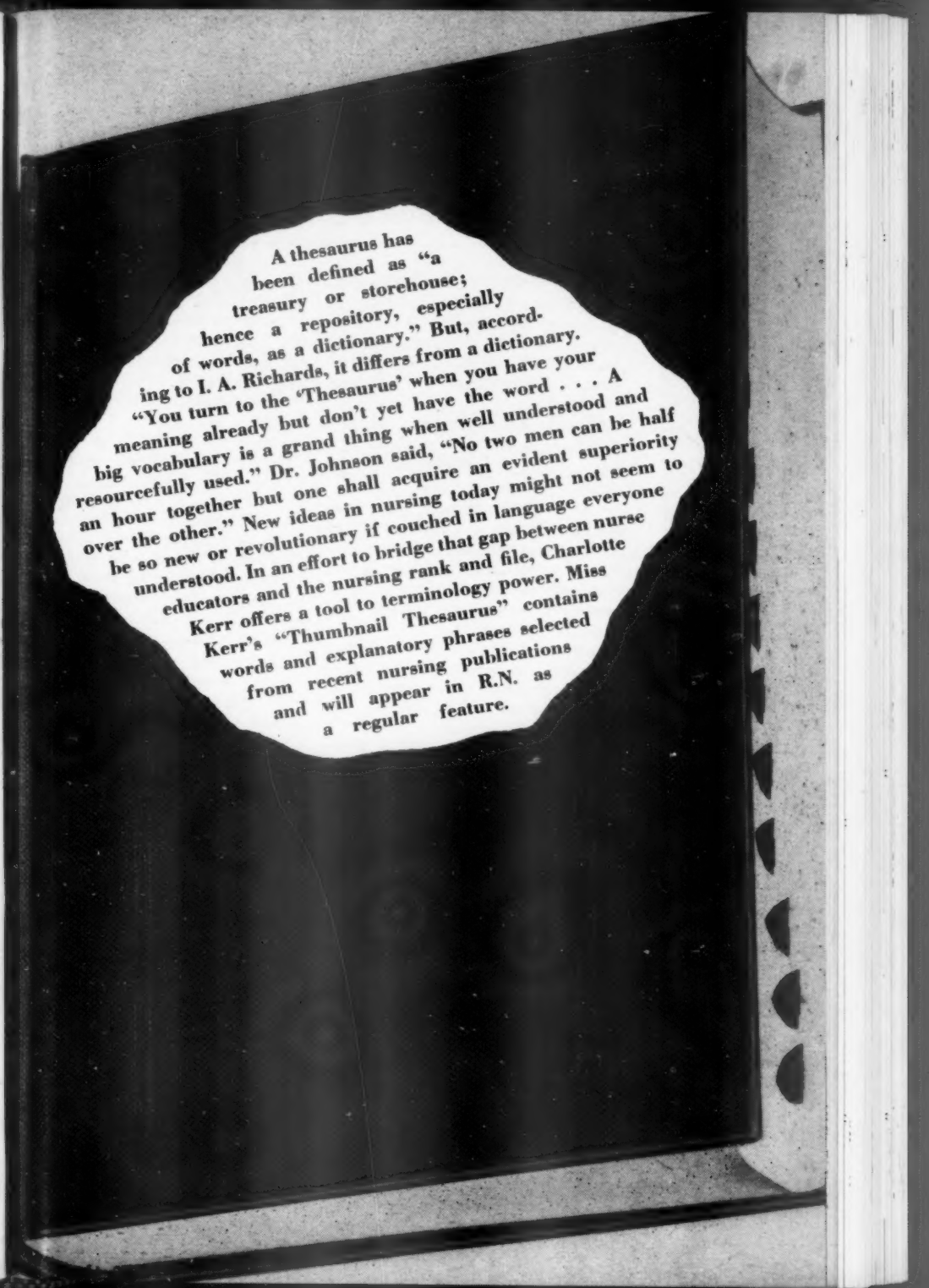

A thesaurus has been defined as "a treasury or storehouse; hence a repository, especially of words, as a dictionary." But, according to I. A. Richards, it differs from a dictionary. "You turn to the 'Thesaurus' when you have your meaning already but don't yet have the word . . . A big vocabulary is a grand thing when well understood and resourcefully used." Dr. Johnson said, "No two men can be half an hour together but one shall acquire an evident superiority over the other." New ideas in nursing today might not seem to be so new or revolutionary if couched in language everyone understood. In an effort to bridge that gap between nurse educators and the nursing rank and file, Charlotte Kerr offers a tool to terminology power. Miss Kerr's "Thumbnail Thesaurus" contains words and explanatory phrases selected from recent nursing publications and will appear in R.N. as a regular feature.

THUMBNAIL THESAURUS I

ACHIEVEMENT: "Something accomplished by valor, boldness or praiseworthy effort;" (*Webster's*) "Proficiency of performance in a given skill or body of knowledge." (*Good's Dictionary of Education*)

NURSING. *Achievement Tests* are designed to measure one's knowledge, skills and understanding in the nursing field.

CRITERION: "A standard of judging; a rule or test by which facts, principles, opinions and conduct are tried in forming a correct judgment respecting them." (*Webster's*)

NURSING. "How much nursing service is required to meet minimum standards in various situations may be used also in determining the criteria of essentiality of thousands of nursing positions." (*Lucile Petry, "AJN," Feb.*, 1951, *p.* 83)

FORMULATE: "To . . . state in exact concise and systematic form." (*Funk and Wagnalls*)

NURSING. "Plans are being formulated for analysis of biographical and sociological information about candidates for nursing schools . . ." ("*AJN*," *Jan.*, 1951, *p.* 5)

GROUP DYNAMICS: NURSING. "The group dynamics process . . . is a method whereby groups of persons may be helped to think together and to act together, and actually to enjoy so doing." It is a "constructive instrumentality for achieving democratic thought and action." (*Esther Lucile Brown, "Nursing for the Future," p.* 20)

GROUP PROCESS: NURSING. "Today the democratic group process places great emphasis upon rotating leadership. An entirely new innovation, the leadership role is tossed from one member of the group to another and all members are expected both to lead and to follow." (*Mildred Newton, "Nursing World," April*, 1951, *p.* 144)

HEALTH: This word has a new meaning! The World Health Organization, in 1941, defined health in its constitution as: "A state of complete physical and social well-being, not merely the absence of disease or infirmity. This is the new look." (*Brock Chisholm, M.D., "The Child," May*, 1948)

NURSING. "Thus far, the major emphasis in medicine has been centered on organic disease. The teachings of preventive medicine, mental hygiene and public health have progressively stressed not only the prevention of disease but the maintenance of health." (*Esther Lucile Brown," Nursing for the Future," p.* 33)

THUMBNAIL THESAURUS I

HEALTH EDUCATION: ". . . a process of change within the human organism itself which is related to achieving personal and community health goals." (*Dorothy Nyswander, "American Journal of Public Health," June,* 1947, *p.* 641)

NURSING. "Health education is more than information about diseases or accident prevention, or the worry about absenteeism. Health education means leading people to be at ease physically and mentally." (*Bruno Gebhard, M.D., "AJN," June,* 1949, *p.* 368)

HEALTH EDUCATOR: ". . . one who, understanding the principles underlying healthy growth and healthful living, is able to speed the process of change within the human organism toward achievement of personal and community health goals." (*Mary Ella Chayer, "Nursing in Modern Society," p.* 209)

NURSING. "No one can tell the industrial nurse exactly how to fulfill her obligation as an industrial health educator. The choice of technics is naturally connected closely with the subject matter." (*Bruno Gebhard, M.D., "AJN," June,* 1949, *p.* 369)

IMPLEMENTATION: Accomplishment, fulfillment, completion, act of carrying out. (*Webster's*)

NURSING. Implementation of aims for nurses means the carrying out of the goals they have set for themselves.

INTEGRAL: "Constituting a completed whole; . . . intrinsic." (*Funk and Wagnalls*)

NURSING. The nurse is an integral part of the medical team (or, she is needed for completeness). "Hospitals are integral units of the community in which they are located and hence nursing finds itself in a cosmopolitan enterprise" . . . (*Lucy D. Germain, "Modern Hospital," April,* 1951, *p.* 61)

INTEGRATION: "Act or process of making whole or entire." (*Webster's*)

NURSING. "Integration, in its widest meaning, refers to the wholeness of the individual; the nurse is an individual who, for her own sake and for the sake of her patients, should be a whole or integrated personality." (*Dorothy Johansen, "AJN," Feb.,* 1950, *p.* 119)

INTEGRITY: "Uprightness of character; . . . honesty; . . . soundness; . . . completeness." (*Funk and Wagnalls*)

NURSING. This desirable quality for a nurse is commonly found on nursing evaluation forms.

MISS ADDAMS? I have a case for you—a tracheotomy at . . . "

At the word *tracheotomy* Miss Addams' heart turned a flipflop. This was it. The case she had always hoped someone else would get. "The trouble with tracheotomies," Miss Addams thought rather ruefully, "is that there are never enough of them so that you have a chance to get used to them, but there's always the possibility that someday you'll have to take care of one." Of course, she could refuse, but few patients need a private nurse more than does the patient with a newly acquired tracheotomy tube. "After all," she told herself, "nurses who work where tracheotomy cases are the rule rather than the exception seem to take them in their stride. Tracheotomies are all in the day's routine to them."

Tracheotomies call for skilled nursing care, and fear of the unfamiliar only makes them that much more difficult. The operation is done when there is an obstruction of the air passages above the trachea which threatens the patient with asphyxia. Sometimes a laryngoscopy is done before the tracheotomy to find the cause of the obstruction. Often, however, there is no time for this. An emergency exists. Dyspnea is usually marked. The patient is easily exhausted, for whenever he dozes off he wakens with a panicky sense of suffocation. This restlessness is particularly noticeable in children. The skin is pale, cold, and "clammy" and

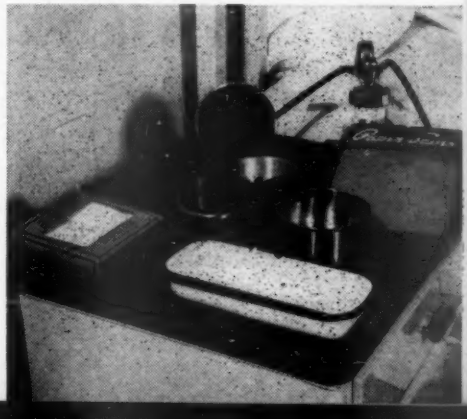
the pulse is usually feeble and rapid.

Doubtlessly the most dramatic use of the tracheotomy, examples of which are to be found in fact, fiction and film, is in laryngeal diphtheria. More frequently however, tracheotomies are indicated where there are tumors of the larynx, upper esophagus, and thyroid or trachea, either benign or malignant. Tracheotomies may sometimes be done where there is a retropharyngeal abscess. Many hospitals have a standing rule that a tracheotomy set shall be in the unit or on the ward whenever there is a postoperative thyroidectomy patient in case edema of the larynx should become so great as to obstruct the patient's airway. Probably, outside of "head and neck" wards in cancer hospitals, the place where tracheotomies are most numerous is on the "polio" ward. Here the care of the tracheotomy is complicated by the fact that these patients are often in respirators.

Tracheotomy tubes are simple affairs. In fact, it is almost unbelievable that such an uncomplicated operation as a tracheotomy can produce such immediate and evident relief in most instances. (The more specific term "tracheostomy" promises to supersede the more familiar tracheotomy—"otomy" alone merely signifies an opening into, while "ostomy" signifies there has been some preparation of the stoma.) There are three parts to a tracheostomy set: an outer tube or cannula, a pilot or obturator and an inner tube. These tubes are usually made of sterling silver, consequently they are rather easy to dent, and must be handled carefully. The three parts must always be kept together, for parts cannot be interchanged, even though both tracheostomy sets are of the same size. After an incision has been made using local anesthesia, or none at all if the emergency is great, the outer tube with the obturator as a

THE TERRIBLE TRACHEOTOMY

by Althea Powers, R.N.



Complete with magic slate, mirror and soap dish for brush and obturator, this stand has everything at hand for the patient or his nurse to care for his tracheostomy with the least effort. The picture at the upper left shows a suction unit with cloth bag for suction tips tied to the bed. (Photos: Memorial Cancer Center Nurses' Quick Reference Book)

guide is inserted. Once the outer tube is in place, the obturator is removed and the inner cannula is substituted for it. The outer tube is fastened around the patient's neck by means of a tape which must be tied securely to preclude the possibility of the outer tube slipping from the incision.

There seems to be some debate as to whether there should be additional moisture in the room of the postoperative tracheostomy patient or not. Ordinarily, the air is warmed, moistened and filtered as it passes through the nose on its way to the lungs. When the air is inhaled directly into the trachea however, it does not have this preparatory treatment. Some authorities advocate the use of steam inhalators, at least in the winter. Others think that a sponge moistened in water or saline and placed over the opening of the tube is effective. But, if this is done, precautions must be taken to see that there are no loose threads to become aspirated into the tube. Although this attention to the humidity may be indicated during the first few postoperative days, Dr. Roy H. Parkinson believes "Many patients wear their tracheostomy tubes for months without difficulty, even though they are outdoors and attending to their usual occupations; for this reason it is obvious that careful attention to the air is unnecessary."*

The patient's inner tube will need suctioning fairly frequently immediately following the operation. If the patient coughs up secretion of his own accord, the nurse should be ready to wipe it away at once; otherwise it is apt to be aspirated back into the tube when the patient takes his next breath. A #14 Whistle tip catheter is ideal for this purpose, but if one is not available a regular catheter can be cut diagonally across the end. The edges should then be rounded off so that they do not irritate the trachea. Usually #8-10 French catheters are indicated for children and #12-16 for adults. Suction should not be too strong, and the catheter should not be introduced much farther than ¼ inch below the tube. If the nurse asks the patient to cough, and then inserts the catheter with the diagonal edge against the wall of the tube and rotates it, all the surfaces of the tube as well as the lumen can be cleaned. Since the airway is obstructed by the catheter during the suctioning process, it is best not to keep the catheter in place for too long a period of time. It is expected that the first drainage from the tube will be blood-tinged mucus. However, if bleeding is at all persistent the physician should be notified, even if it is only a small amount, as there may be internal hemorrhage

The inner cannula tends to fill with sticky, dry mucus that cannot be adequately removed by suctioning, and when this does occur it becomes necessary to remove the inner tube. Usually this must be done at least every two hours postoperatively. The fastener that locks the cannula in

*Eye, Ear, Nose, and Throat Manual for Nurses, 6th Ed., C. V. Mosby Co., St. Louis. p. 136.

place must be turned, and then the cannula can usually be lifted out without difficulty. It can be cleaned under running water, using a small test tube brush, or pipe cleaners work very well for the smaller type tubes. If the mucus is tenacious, soda bicarbonate solution or hydrogen peroxide may be used. The outer tube should be aspirated, and the inner tube, before re-insertion, should be rinsed thoroughly so that there are no bristles left in it from the brush. Be sure the tube is re-locked in place.

Whether the inner cannula should be sterilized or not before re-insertion seems to be a matter which each institution decides for itself. However, in view of the fact that it is wise to replace the cannula as quickly as possible, and since tracheostomy parts cannot be interchanged, there seems to be a tendency toward replacing the cannula without taking the time to boil or soak it. Of course, precautions are taken to keep the tube as clean as possible.

Warning: *The outer tube is never removed by the nurse.* Tracheostomy tubes usually stay in place if they are handled with respect, but sometimes swelling at the site of operation may expel the outer tube. If this happens, or if the tubing comes out inadvertently, the tracheal incision should be held apart by a dilator or hemostat until the doctor arrives. Another sterile tracheostomy set should be readily available at all times.

Tracheostomy incisions also need to be dressed. [*Continued on page* 76]

A CHANCE TO HELP

The Easter Seal campaign, sponsored annually by the National Society for Crippled Children and Adults, the Easter Seal Society, and its affiliates, will open March 13. Services and facilities operated by the Easter Seal Societies or in development during 1951 include 114 out-patient treatment-training centers for crippled children and those with cerebral palsy, 58 evaluation and diagnostic clinics, 40 additional facilities receiving either funds or services of a therapist, 25 speech centers, 25 centers of various kinds now in the planning stage, 10 residential facilities, 81 camps for crippled children, and assistance in special education for crippled children to 158 public school systems. Direct services to more than 300,000 disabled children and adults were given during the past year. The number of professional persons trained for specialized work with crippled children, under fellowships, grants, scholarships and workshops of the Easter Seal Societies, now totals 700. The campaign closes Easter Sunday, April 13.

REVIEWING THE NEWS

▶A SPECIAL PREVIEW of the British film, "Lady With A Lamp," was seen by nurses attending the annual January meeting of the ANA Advisory Council. Many of the incidents in the movie, which stars Anna Neagle as Florence Nightingale and Michael Wilding as Sidney Herbert, are those depicted in Cecil Woodham-Smith's bestseller, *Florence Nightingale, 1820-1910* (McGraw-Hill Book Co., Inc., New York, N.Y.) Previous to the showing, Advisory Council members approved of a proposed project whereby funds obtained from the film's premieres in several large cities might be used by the ANA for a charitable cause, such as scholarships for nursing students. It was pointed out that at the London premiere, £40,000 was raised for educational programs for graduate nurses at the Royal College of Nursing.

▶CALLING NOPHN MEMBERS: If the proposed National League for Nursing, formerly known as the Nursing League of America, is to begin functioning in June, two-thirds of all NOPHN members must vote "yes" on re-organization plans and return their proxies before the Biennial Convention, June 16-20. Because membership corporation laws of New York State, where NOPHN is incorporated, demand a two-thirds vote, every NOPHN member must vote and vote soon if a costly and perhaps long court procedure is to be avoided, according to Emilie G. Sargent, NOPHN president. Ninety-one per cent of the NOPHN members who voted in May, 1950, were in favor of the re-organization plan. Convention notices and proxies will continue to be mailed to all members as dues come in, but anyone wishing to join should do so now since a deadline will have to be set—probably in May. All 1952 NOPHN members are entitled to 1952 membership as charter members of the National League for Nursing.

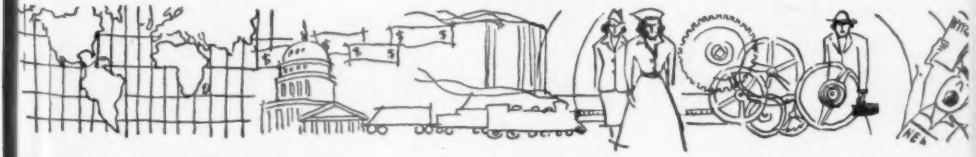
▶WITH THIS ISSUE, **R.N.** welcomes Mrs. Margaret W. Lucal to its Advisory Board. As the newest member of the Board, Mrs. Lucal brings to **R.N.** a wide variety of experience garnered from 6 years of public health nursing, 10 years of hospital administration and 15 years of industrial nursing. Well-known in national and state nursing circles as the treasurer of the American Association of Industrial Nurses, president of the Ohio Industrial Nurses Association and chairman of the AAIN Structure Committee, Mrs. Lucal has served

nurses in industry for several years in various official capacities; in 1949, she was appointed to the USPHS Industrial Hygiene Advisory Committee. Currently, Mrs. Lucal, a graduate of the Lutheran Hospital Training School for Nurses, Cleveland, Ohio, is employed as supervisor of the Medical Department of the Ohio Rubber Co. in Willoughby, Ohio.

▶ COURSES AND INSTITUTES: A new six-weeks' course in Premature Infant Nursing is offered this spring by the Department of Nursing Education, Louisiana State University, New Orleans. In addition to theory, the course includes field experience in the Premature Infant Station of the New Orleans Charity Hospital. Four semester hours of credit are allowed for the course. Beginning dates are March 3, April 21, Sept. 15 and Nov. 3. A 9-credit, one semester course in advanced surgical nursing which includes both theory and field practice is also being initiated by this school . . . Saint Elizabeth School of Nursing, Covington, Kentucky, held an Institute on Polio Nursing, Febuary 11th through the 15th, for instructors and head nurses at its own hospital. Other institutions in the vicinity were invited to send representatives to join in the course. Miss Theresa Fallon, consultant from the New York offices of the NFIP, was in charge of the Institute. Saint Elizabeth's is believed to be the only basic diploma program in Kentucky preparing to incorporate this type of nursing into its basic program.

▶ STATE SCHOLARSHIPS in nursing education were recently awarded by Connecticut. Eighty of the 92 scholarships offered went to girls just entering nursing schools and 12 were given to students in the second or third year of nurses' training. Sixteen of the 21 schools of nursing in Connecticut participate in the scholarship program financed out of a $140,000 fund appropriated by the 1951 Connecticut General Assembly. Connecticut is reportedly the first state to take definite action toward solving the civilian nursing shortage by a scholarship bill presented in 1949 to its legislature.

▶ THE COMMISSION on the Health Needs of the Nation, despite its stormy reception in some quarters, seems to be quietly settling down to its difficult task. Headed by Dr. Paul B. Magnuson, former Medical Director of the VA, the 15-member commission is to make a critical study within a year of "the nation's total health requirements and to recommend courses of action to meet these needs." Members, nominated by Dr. Magnuson and appointed by [*Continued on page* 66]



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Blood Derivatives

[*Continued from page* 43]

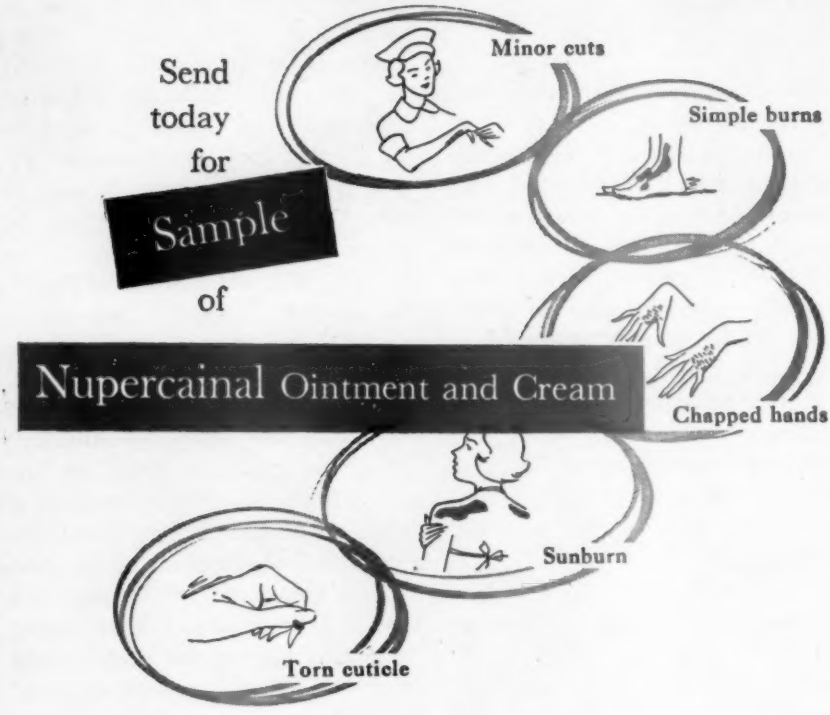
red blood corpuscles is considered essential. Obviously, it is not effective in diseases which require the clotting factors of the blood.

Serum albumin, the protein which accounts for approximately half of the protein in plasma, served as a therapeutic weapon against shock during World War II. Because it could be packaged in small vials, it was carried by paratroopers and submarines; it is now being stockpiled in defense centers and hospitals. Both serum albumin and plasma are discussed in more detail in *Drug Digest*, page 44.

For some time attempts have been made to develop plasma substitutes which will have the colloidal and osmotic characteristics of plasma. Recently these efforts have received added impetus because of the threat of atomic warfare. It has been estimated that an average-size city hit by one bomb would require 40,000 units of blood or blood derivatives during the first week and as much during the second and third weeks. Plasma and blood would be needed for burns and injuries from blast as well as for radiation sickness, for the chief effect of radiation is the destruction of the blood-making organs. In preparing for such a disaster, there must be stockpiles of plasma serum albumin and other medicines which could serve as shock-fighters until adequate supplies of whole blood could meet the emergency demand. Whole blood, it may be remembered, cannot be kept in reserve longer than 21 days.

As a result of the imperative need for increasing our supply of blood derivatives and blood supportives and also for meeting the blood requirements of our fighting men in Korea, the American Red Cross, in cooperation with the American Association of Blood Banks, the American Medical Association, the American Hospital Association and the College of American Pathologists, has taken over the responsibility of serving as the official coordinating agency to procure blood for the armed forces, as well as conducting a nationwide civil defense blood program. The Department of Defense and the Office of Civil Defense will pay for the expense of procuring blood and making the plasma from the blood which has been collected for them.

So far, the National Research Council has approved the plasma "substitutes" dextran and gelatin for stockpiling. Limited approval has also been given for stockpiling polyvinylpyrrolidone for emergency use only. Dextran, a glucose polymer, similar to glycogen, was developed in Sweden after World War II, and has been widely employed in Europe for the treatment of shock. It is administered as a 6 per cent solution in normal saline. Studies are now being made to determine its metabolic fate in the body, for although it does not appear toxic, allergic reactions have been observed. Special Gelatine Solution, Intravenous 6% and polyvinylpyrrolidone



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are described in *Drug Digest*, page 44.

Other substances which are reported capable of supporting blood volume in shock and relieving edema in nephrosis include a 6 to 7 per cent solution of acacia (gum arabic), bovine serum albumin, pectin and a mucilagenous polysaccharide derived from okra. According to the AMA Council on Pharmacy and Chemistry, acacia, which appears to be stored in the liver and other organs, may "interfere with hepatic function and delay the regeneration of serum protein."[5] It may also cause allergic reactions in sensitive persons. The use of bovine albumin may transmit tuberculosis or undulant fever, and the processing required to avoid protein and antibody reactions is expensive and difficult. Since the metabolic fate of pectin is not known, this fact alone does not allow it to be classified as a reliable "substitute." The clinical value of the okra derivative has not yet been determined. In addition to these substances, studies are being made on the efficacy of isinglass, glutamic acid polypeptide and sodium glycerol polysuccinate. The Council emphasizes that the artificial colloids available should not be used in the treatment of shock except in emergencies and that such "substitutes" should be looked upon as temporary supportive agents of blood volume and arterial pressure rather than as replacements. It also states that "Until more is known of the effectiveness and ultimate metabolism of the synthetic materials, their clinical application should be restricted to investigational use except for purposes of stockpiling for emergency."[6] For the present, and probably for some time to come, the therapeutic superiority of human blood and its derivatives will remain unquestioned.

1. *Blood and Plasma Transfusions*, **F. A.** Davis Co., Philadelphia, p. 17.
2. *Ibid*, p. 114.
3. *JAMA*, October 13, 1951, p. 658.
4. *Blood and Plasma Transfusions*, **op. cit.**, p. 117.
5. *JAMA*, October 13, 1951, p. 659.
6. *Ibid*, p. 660.

R.N. is no longer accepting orders for the *first* set of Drug Digest cards. The second and latest set of 48 cards may be obtained by sending $1.00 to Editor, R.N., The Nightingale Press, Rutherford, N.J.

World's A Stage

[*Continued from page* 32]

A mid-winter blizzard was noisily in the making outside and my husband had stopped in for a five-minute look which, as emergency after emergency kept coming in, ran to three hours and more. When I entered the room, Fred and The Woman sat in a corner, discussing what Fred should do when She was gone. The Woman, with a rare social consciousness, turned to me and explained. "Fred's mother, here—she's awful low, and Fred's waiting up the night. She's in a ward, you know, so he can't stay with her. And I'm sitting up with Fred. Didn't want him to be alone; its awful lonely here all night."

I agreed, and said I thought that was very nice of her. She went on, "Fred's mother, here, she told him she didn't hold him to no promise to stay on the farm after she's gone, and I'm telling him I think he ought to move to town and take it easy. Now what do you think?" I agreed it might be far more comfortable for Fred.

Just then a tall, graying man entered, and The Woman, sitting like the queen in Alice in Wonderland, explained it all to him, and with open interest asked if he had someone in. The man said his name was Russell, and explained that he was a retired Chicago policeman, who, like an old fire horse, often hung around the station just to see what was going on. This night the police had picked up a fellow who had been hurt in a


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brawl, and he had gone along to the hospital while Riley saw him patched up. Fred's round face gleamed with interest.

"Now you don't say—a Chicago policeman—I'll bet you've seen some good scraps." He leaned forward like a small boy asking for a story. Russell looked at him, sensed his hunger and obliged.

"Well—I guess the closest one came when I accidentally walked in on a restaurant holdup. Just dropped in for a cup of coffee, and here's this guy, about Fred's build—has a gun on the proprietor."

His story was interrupted by the arrival of a tall dark man in a plaid jacket sparkling with snow. He stomped, shook himself, and grinning, sat down. The Woman performed the amenities—Fred, whose mother was awful low, me, the lady in the corner, waiting for her husband, Russell, a retired policeman who'd been to a brawl—and did he have somebody *in*?

"Just brought my wife in," he commented, taking off his boots.

"Oh now, is she going to have an operation tomorrow?" asked the Woman, her voice tremulous with concern.

"Nope—she's just going to born a baby." My feminine blood rose at the casual "just" qualifying the "borning" process. Fred turned toward him, beaming.

"Now isn't that nice—I'll bet you're going to be proud. This your first?"

"Nope—the sixth—our baby is eight," he smiled, apologetically.

There was a silence, while Fred and the Woman considered. "Well—they're always welcome, I always say," said the Woman in a tone which still conveyed a suggestion of doubt. And to cover the slight embarrassment over the propriety of a sixth baby, they asked Russell to go on with the holdup story.

And from there on the conversation flowed smoothly, never lacking a subject, with occasional moments of silence to savor a situation or a memory. Fred told us about his early days in a logging camp on Lake Superior up near Paradise, where it's lonely all year and cruelly cold in winter. He told about bears, and broken legs, and blizzards. McNab

(for that was his name, in spite of the French blood in his veins) had tales of taking his snowplow into the backwoods places to bring out women in labor, and fighting his way through blizzards to the main highways. Russell got us through the holdup, a couple of murders and a warehouse burglary. The Woman of the Good Heart spoke of the people who had lived in the town and gone on, and they lived for her so vividly, they lived for us too. Story followed story, and when the policeman who had brought in the drunk stopped in to ask Russell if he wanted to go, Russell said he guessed he'd stay a bit and help keep Fred company. After a while a nurse came down and told McNab he had a fine eight-pound son. He went away, then came back to tell us about the delivery and the baby, and said he didn't have any place in particular to go; he guessed he'd stay and keep Fred company. Then, my husband, in his white coat, stuck his head in the door and said he'd be ready in a minute, and I was betrayed—I was no longer one of them. The Woman of the Good Heart spoke kindly "Now—I'm sorry you have to go—I thought you was going to stay up all night with us too."

I almost wished I was. But wouldn't Bill have been surprised if I had told him I guessed I'd just stay and keep Fred company?

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News

[*Continued from page* 55]

the President, are representatives of the medical profession, educational and research institutions, and farm, labor and consumer organizations. Sole representative of the nursing profession is Marion W. Sheahan, director of the National Committee for the Improvement of Nursing Services.

Dr. Magnuson, an opponent of compulsory national health programs, envisions the problem before the commission as a threefold one of prevention, actual care of the sick, and rehabilitation.

▶ ABOUT PEOPLE: A member of the class of 1883, Bellevue School of Nursing, *Anna B. Clark*, 97, died January 6th. Until her death, Miss Clark was the oldest living graduate of the school. The last surviving member of the class is *Mrs. Elizabeth Wilcox Beckwith* who now resides in Connecticut . . . *Margaret A. Losty* has been appointed director of the new division of nursing services for the National Foundation for Infantile Paralysis. A former senior hospital nursing consultant for New York City's Department of Health, Miss Losty will act as consultant on nursing problems and as liaison officer between NFIP and other organizations concerned with providing nursing service for polio patients . . . Promotion of *Mildred Terrill* to Commander has been announced by the Navy Nurse Corps . . . Memorial services for *Emijean Snedegar*, the

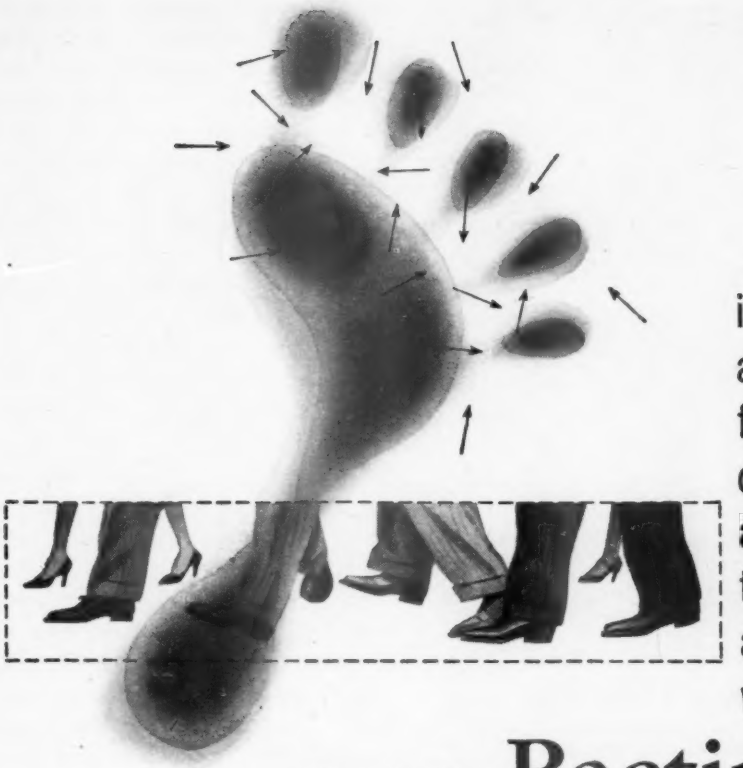
USPHS nurse officer killed in a plane crash near Teheran, Iran, were held at the State Department. She was assigned to this department as director of nursing in its health program for foreign service employes and was making an inspection tour of embassy stations at the time of her death . . . Voted "Nurse of the Year" at William Beaumont Army Hospital, Ft. Bliss, Tex., *Capt. Mabel Barbour* of Midland, Ohio has been a nurse for 23 years and a member of the Army Nurse Corps for 10 years . . . *Ruth Freeman* of the faculty of Johns Hopkins University has been appointed a member of the editors' board for *Public Health Reports*, a new monthly publication of the USPHS . . . A team of twin nurses at Detroit Receiving Hospital was broken up when one of them, *Mrs. Evelyn Ransom*, announced her retirement. Mrs. Ransom plans to do private duty nursing in Detroit following a three months' vacation in Florida. Her sister, *Mrs. Dorothy Arndt* will be eligible for retirement next year . . . *Elizabeth Sutcliffe* is the new ARC nursing field representative for Southern Illinois. Prior to joining the Red Cross staff, she served as director of Nursing Services, University of Kansas Department of Nursing, Kansas City, Kansas.

▶ CONCLAVES: The Conference of Catholic Schools of Nursing will hold its annual meeting in Cleveland, May 24-25. The sixth biennial convention of the National Council of Catholic Nurses is scheduled for May 1-4, at the Hotel Statler in

the same city . . . The 37th annual conference of the New England Industrial Nurses Association will be held on May 9, 10, and 11 at the Hotel Kimball, Springfield, Mass. . . . San Francisco has been chosen as the site for the annual convention of the National Society for Crippled Children and Adults, October 25 through 30, 1952.

▶ AMA DECIDES: Voting at its interim meeting in Los Angeles to continue its campaign against compulsory health insurance, the house of delegates reduced its expenditures for the campaign to an estimated $250,000—less than half of the 1951 outlay. Whitaker and Baxter were retained as part-time counselors only . . . Following a recommendation of its Board of Trustees, the house of delegates adopted a less rigid version of the Hess-Askey report. The new policy no longer threatens to deprive "recalcitrant" hospitals of AMA approval for internship or residency training but makes physicians alone responsible for their "unethical" actions. Three main principles are set forth in the latest version: A physician should not dispense of his services under conditions where such services are likely to be resold; if the physician's services are not resold, financial arrangements between physician and hospital may be arranged to their mutual satisfaction; and anesthesiology, pathology, physiotherapy and radiology are considered an integral part of medical practice. The new policy is believed to be more conciliatory because of opinions of AMA legal counsel that the courts would not uphold the AMA in disputes with refractory hospitals

▶ CAPITOL COPY: Although restating his own preference for national health insurance in his "State of the Union" message, President Truman refrained from asking for its adoption by Congress. Instead, he asked for expansion of aid to local health departments and for federal financial assistance to medical and other health education in health sciences . . . A preview of the United States' health and hospital budget for the fiscal year 1953 allots $2.1 billion to the USPHS, VA medical functions and other non-military



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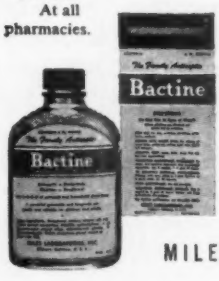

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health activities. The Hill-Burton hospital expansion bill accounts for another $75 million . . . At the close of 1951 there were 766 Hill-Burton hospitals under construction. Since the program was begun five years ago, 781 hospitals have been completed. Another 165 projects are in the pre-construction stage . . . Elmer B. Staats, assistant director of the Budget Bureau, speaking at the annual Federal Hospital luncheon, asserted that one American in six stood to benefit directly from federal medical or hospital services: nineteen million veterans, more than 3.5 million military personnel and dependents, over 2 million federal employes, 400,000 Indians and 100,000 merchant seamen . . . At this writing, only 13 states are participants in the fund-matching program to enable them to stockpile medical supplies and equipment for civil defense. Ten other applications are pending. New York State and California are the only states that have received more than $1 million, with New York accounting for more than 60 per cent of funds allotted . . . Proposing to extend public assistance benefits under the Social Security Act to persons under care in private institutions who are now ineligible by law, H.R. 6078 introduced by Rep. Gerald R. Ford, Jr. (R-Mich.) would affect indigent individuals 65 and older, the blind, and persons 18 or older who are totally and permanently disabled. Cases under care in public hospitals and sanatoria would continue to receive no financial assistance.

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Candid Comments

[*Continued from page* 39]

them wanting, what do we have to offer in their place? They were designed, rightly or wrongly, in an honest, hard-wrought effort to meet new and pressing needs. Those who protest must design what they believe to be a better plan.

The shortage of nurses is rapidly becoming a seriously acute crisis. Thousands of positions in which nurses are greatly needed are unfilled. The number of unfilled calls on our registries is the highest in history—it is shockingly high, for private duty calls today usually represent acute need. In Texas, for example, the statewide average of unfilled calls in 1949 was 17 per cent. In 1951 this was almost 23 per cent. Shortages in any necessary services or commodity always bring substitutes. If we are against the substitutes used in getting the nursing job done—or against the policies that govern their use, have we something better to offer?

We need bigness today—a bigness in our minds and spirits that measures up to the bigness of our profession's place in the world. We need it in all nurses, in followers as well as leaders, in elected officers as well as in those who elect them. The quality of our leadership will increasingly be put to the test. The leadership that rises to our need isn't bestowed by divine right nor necessarily earned by academic degrees or seniority. It rises out of the ranks because a natural talent has been disciplined by

successful experiences in dealing with people—and tempered by a reverence for their needs, their viewpoints and their prerogatives.

If our leadership rises from the ranks, it follows then that within the ranks there must be greater vision and a greater experience in the disciplines of gaining our ends through group action. We can belong to a profession without being professional—and one of the tests here is the extent of our interests beyond our own front doors. We need more leaders, many more—and a *new type of leader* to meet the growing new challenges. Every practicing nurse is a shareholder in the profits and losses of the profession, and therefore every nurse has certain inherent privileges and duties.

It is one thing to want to help, and another to know how to help. I believe some of the frustrations of nurses who drop their membership or fail ever to join their professional association are due to a sense of futility. They believe they "cannot get to first base." Hence it is of first importance for members to know their power to act and to realize that the district—right where they live—is a fine training ground both for citizenship in nursing and for leadership. Every district member has two powerful tools—the voice and the vote. Our failure to use these tools correctly is one of our greatest weaknesses. We see the machinery of organization work, we hear reports, and sometimes we second a motion, but not enough of us understand the parliamentary principles that provide

every member with power, and ensure to them certain rights.

Our associations, from district to national, have their constitutions and by-laws established on parliamentary law. That provides orderly and equitable ways of doing business. "Parliamentary law," says Mrs. Harvey Thomas, ANA parliamentarian, and an authority on the subject, "is designed to give equal rights to every member present at a meeting, and to protect the members who are absent." The protection lies in the fact that the constitution and by-laws cannot be changed without due notice and without the consent of the majority. "Equal rights" involve not only the voting franchise but the prerogative to share in all affairs of the association. To facilitate association affairs, boards act for the members, but their actions are—or should be—open to all the members for scrutiny and challenge.

The degree in which members actually participate depends as much upon their own attitudes and knowledge of parliamentary procedures as it does upon those of the leader. Our greatest security lies in group action; our greatest promise lies in the participation of the majority in this action. Many of us are deeply worried over some of the trends and practices today. Only when we turn our worry into work for better things can that worry count. Years ago a man wrote to a friend—"I want to help you to grow as beautiful as God meant you to be when He thought of you first." I believe the majority of us want our profession to grow as beautiful as God meant it to be when He thought of it first. And that means work as well as hope.

Delegates to the 1952 Biennial Convention *may* register in advance this year. Advance registration cards, now available to ANA, NLNE and NOPHN members, should be returned with check or money order for $5.00 to cover the registration fee. Checks should be made payable to 1952 Biennial Nursing Convention, and should be mailed to that department at 2 Park Ave., New York 16, N.Y. before May 10. Early registrants will be sent receipts which, when presented at the Advance Registration Window in Convention Hall, Atlantic City, will ensure each delegate her badge.

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Burgess, T. S. *Jour. Med. Assn. Georgia*, 37:44, Feb., 1948.

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Tracheotomy

[*Continued from page* 53]

Customarily, a gauze square is slit to the midpoint and fitted around the tube. This is a particularly ticklish business since care must be exercised not to loosen the outer tube while fitting the dressing around it. When the dressing is in place, the slit can be closed by a strip of adhesive tape which will also anchor the dressing to the neck.

There is an absence of the cartilaginous rings between the trachea and the esophagus which prevents any pressure of the trachea upon the esophagus, therefore most patients are able to swallow in spite of the presence of the tube.

Usually liquids only are allowed at first until the patient becomes accustomed to the tracheal tube. Sometimes, as in certain cases of poliomyelitis and cancer, the patient must be tube fed. A catheter may be passed nasally and the patient fed by this method, the catheter being changed at regular intervals by the doctor.

Feeding is not the only problem encountered in the "polio" patient with a tracheostomy. When these patients are in respirators, as so frequently happens, the nurse must see that the respirator collar fits snugly around the patient's neck without blocking the patient's airway. Various devices have been invented by ingenious nurses and doctors to keep the collar away from the tube and yet tight about the patient's neck. The respirator is usually tipped at a 30 degree angle to extend the patient's neck away from the collar and also to facilitate drainage from the lungs.

Although the patient is somewhat overwhelmed at first by this strange thing that has happened to him, he soon learns how to care for his own tracheostomy. He can do a much better job of it if he is provided with a mirror to enable him to see what he is doing. A soap dish of the right size makes a convenient place to store his obturator and the brush that he uses to clean the inner cannula. Since a tracheostomy patient cannot talk unless he places his finger over the opening of the tube, he should be supplied with paper and

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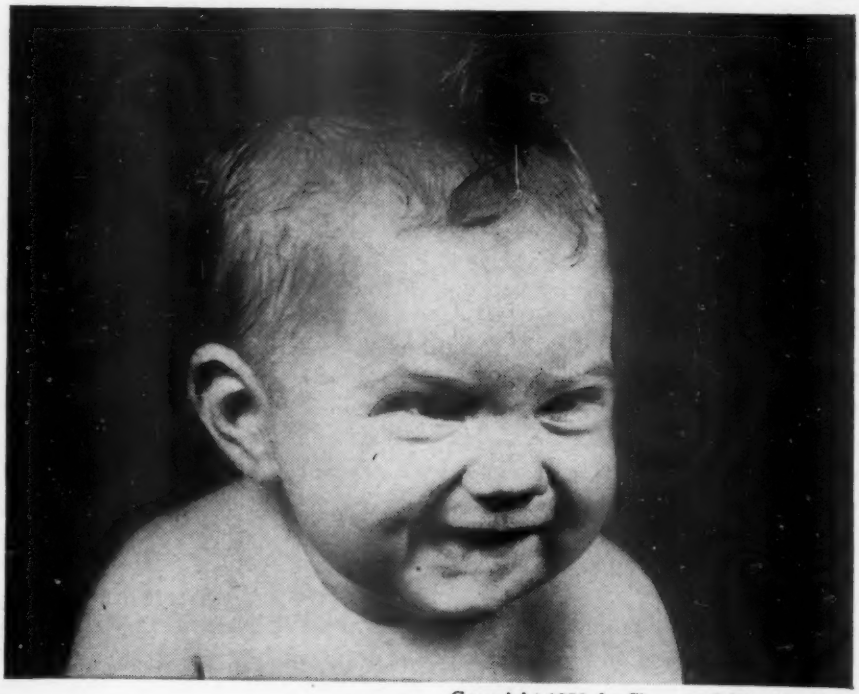

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pencil to make his requests known. A magic slate which can be bought at almost any "5 & 10" serves this purpose very well.

Many patients have permanent tracheostomies and have to learn to live with them for the rest of their lives. This is not true in most cases, however. Once the emergency is passed and the patient begins to recover, the process of decannularization is begun. A graduated series of corks made from a special grade of rubber is inserted in the opening, each cork cutting off more air than the preceding one. When the patient reaches the point where he can go for a day and a night with the tracheal opening completely occluded, he is ready to have the tube removed. Sometimes adhesive is used in place of the corks to test the patient's ability to go without the tube. Needless to say, he should be watched closely for any sign of respiratory difficulty.

To a tracheostomy patient, his operation is a matter of the greatest import. Once the initial relief provided by the operation has lessened, he may become extremely apprehensive, his fear turning into panic when he realizes his inability to communicate vocally. The attitude of the nurse toward the patient in the period immediately following tracheostomy is of great importance in determining his attitude toward the tube. The patient who sees his nurse acting matter-of-factly toward his tube learns to accept it much more quickly than does the patient whose nurse becomes flustered and overanxious. In fact, patients sometimes become too dependent upon their tubes and become greatly alarmed during the period of decannularization. Once again, it is the attitude of the nurse which helps the patient over this "hump." Other patients whose tracheostomies are permanent must be taught how to live normal lives with a minimum of disability.

A new pamphlet, prepared by two nursing instructors, should bring inactive nurses up-to-date on the care of the bed patient's skin. The 12-page booklet "On Guard Against the Wear and Tear of Lying Abed," may be obtained free of charge from Edison Chemical Co., 30 W. Washington, Chicago 2, Ill.

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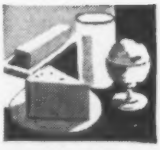
The functions as well as the nature of the nutrients of milk are revealed by research. In the laboratory, scientists have solved a puzzling nutritional "mystery"—why milk is helpful in the dietary treatment of niacin deficiencies. It is because tryptophane, an amino acid present in milk, can form niacin in the body.[3]

Many such instances of interrelationships between nutrients emphasize the importance of milk as a "nutritional whole." Two examples worthy of note are the physiologically desirable ratio between calcium, phosphorus, and magnesium in milk,[4] and the favorable effect of lactose on the absorption of calcium,[5] and possibly of other minerals.

The beneficial effects of dairy foods—milk, butter, cheese, ice cream—on our national health are constantly demonstrated by research.



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ANESTHETIST: (a) To administer anes. for 2 surgeons, town 35,000, S. $400 up. (b) Modern, gen'l hosp. serving employees, large Amer. co., foreign country; $590 which incls. mtce. allowance. (c) Ass'n with group of med. anesthesiologists, univ. center, MW. (d) Gen. hosp., 200 beds, resort town, Michigan, $450, maintenance, RN3-2 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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ASST. SURGERY SUPERVISOR: Also, Operating Room Staff Nurses needed immediately. 5 day, 40 hour week. Salary open. Inquire Director of Nurses, Palo Alto Hospital, Palo Alto, Calif.

COLLEGE NURSES: (a) Direct. health prog., liberal arts college, small town, near univ. center, MW. $4000. (b) Small college, Pac, NW. RN3-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

DIRECTOR OF NURSES: 100 bed general hospital in large metropolitan area. No training school. 40 hr. week, salary open. Box HMC-1 c/o R.N. Rutherford, N.J.

DIRECTORS OF NURSES: (a) 100 bed modern hospital, pleasant community, eastern Arizona. (b) Large teaching hospital, excellent southern California city 10,000, vicinity state capital. Degree, experience desired. Excellent salary. (d) Associate Director. 200 bed hospital, Colorado resort city. 40 hr. week, $3600 up. (e) Small general hospital, southwestern Florida, good salary plus maintenance. (f) 80 bed Illinois hospital with approved school of nursing. To $5400 maintenance. (g) Small, new hospital, southeastern Michigan. $5000. (h) Large teaching hospital, eastern city 200,000. $5500. (i) 150 bed hospital, SW Ohio. $5000 maintenance. (j) Psychiatric hospital near New York. $4800 up. (k) 200 bed pediatric hospital, teaching unit of eastern university. $6000 maintenance. (l) 240 bed teaching hospital, east central city 80,000. To $7200. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

DIRECTORS OF NURSES: (a) Beautiful new hosp., 350 beds, 125 students, town 100,000, E. Minn. $6000. (b) Small gen. hosp. operated by group of Board specialists, attrac. location, Calif. (c) Gen'l, 300 bed hosp. near univ. center, MW, $6000 up. RN3-4 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

DIRECTORS OF NURSING SERVICE: (a) Univ. hosp., 600 beds, min. $5000 mtce, S. (b)

New hosp., small size, resid. town, near NYC. (c) New hosp. 90 beds, college town, SW. RN3-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

EDUCATIONAL DIRECTOR: For accredited school of nursing connected with 330 bed general hospital. 1 class admitted annually. Plans for university association. Salary open, 44 hour week, 8 holidays, 4 weeks vacation, 12 days sick leave. Apply Director of Nursing, Perth Amboy General Hospital, Perth Amboy, N.J.

FACULTY APPOINTMENTS: (a) Assistant Director, southern college of nursing. $5000. (b) Director of Nursing Education. Large eastern psychiatric hospital. $4500 up. (c) Instructor Medical-Surgical Nursing. 180 bed teaching hospital, western university city. $3600 minimum. (d) Clinical Instructor, Medical-Surgical department, midwest college of nursing. $5000. (e) Nursing Arts Instructor. 125 bed Pennsylvania hospital. $3600, maintenance, 40 hr. week, excellent personnel policies. (f) Science Instructor. 300 bed Pennsylvania hospital, good salary. (g) Psychiatric Instructor. Large eastern hospital. To $4200. (h) Social Science Instructor. 200 bed hospital, east central city, good salary and maintenance. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

FACULTY POSTS: (a) Ed. Dir. gen'l hosp. seaport resort town. West Indies. (b) Instructors in Ob-Gyne., neurological & surg. nursing, lge. teaching hosp. univ. med. center, $4500. (c) Science and clinical instrs. in med., surg., ped., important hosp. Calif. (d) Educ. dir. and nursing arts instruc. small hosp. college town near Chgo. $6000, $4800, respectively, mtce. RN3-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY NURSE: 13 bed community hospital. $175 a month, full maintenance, 48 hr. week, rotating shifts. Transportation from Seattle to hospital refunded after year service. 2 wks. paid vacation. Beautiful town among mountains of inland passage, Southeast Alaska. Bishop Rowe General Hospital, Wrangell, Alaska.

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GENERAL DUTY NURSES: Three. 42 bed general hospital. Starting salary $220 per month, rotating shifts, $10 extra for evening and night duty. Two weeks vacation, sick leave, 7 holidays, 44 hour week. Apply Director of Nurses, Prescott Community Hospital, Prescott, Ariz.

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GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary $225, $5 per month tenure increase for each 6 months of service to a maximum of $255. Two meals daily, Social Security, sick leave prepaid, medical and hospital care, $10 additional for afternoon and night duty, $15 additional for delivery room, $20 additional for surgery. Up to 3 weeks vacation at end of 5 years, 6 paid holidays, 8 hour day, 40 hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GENERAL STAFF NURSES: 200-300 bed hospital (100 beds open March 1952). Liberal personnel policies including a 40 hour week. Write: Director of Nursing, Holston Valley Community Hospital, Kingsport, Tenn.

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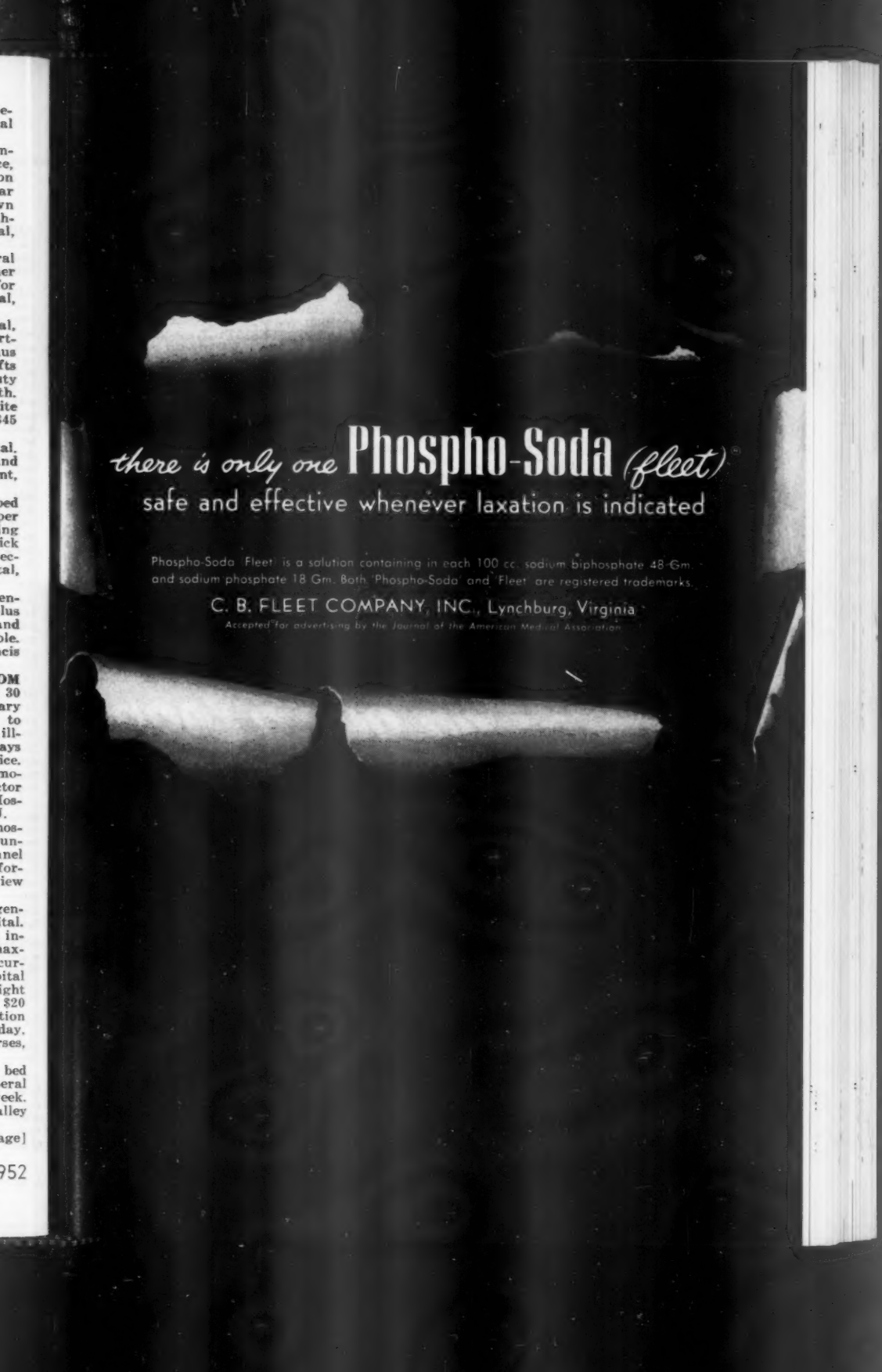
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INSTRUCTOR AND SUPERVISOR: 165 bed general hospital in residential suburb of Chicago. Duties primarily teaching and supervision of auxiliary nursing personnel. 44 hour week. Cash salary $265 plus full maintenance in new nurses' residence. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

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MALE NURSES: (a) O.R. supervisor, 175 bed hosp., So. (b) Instructors, supervisors & staff, large hosp., N&M, E. RN3-8 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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NURSES: For 90 bed hospital. 40 hour week, sick leave and vacation with pay and other benefits of State Merit System. Salaries: Charge Nurse, $260, (2 years of hospital nursing required), Nurse, $220. Apply Superintendent of Nurses, State Tuberculosis Hospital, Gooding, Idaho.

NURSES: General Duty, for 30 bed hospital. 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

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OBSTETRICAL NURSE: Research in hospital, out-patient, abnormal, obstetrics clinic. Beginning salary $270 with advancement to $345. Required: 3 academic quarters course in public health with 2 years experience in generalized public health program. Write Miss Theodora Floyd, Director, Nursing Division, Georgia Department of Public Health, Atlanta, Ga.

O.R. AND GENERAL DUTY NURSES: Real opportunity, small hospital, The Loudoun County Hospital, Inc., Leesburg, Va.

O.R. NURSE: Single, experienced in surgical technique, salary and full maintenance. Live on premises. Apply Mary E. Sperry, Director of Nurses, Beth Israel Hospital, 1601 Lowell Blvd., Denver, Colo. AC-4718.

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OPERATING ROOM SCRUB NURSE: Experienced. 60 bed non-profit hospital at Carmel-by-the-Sea. Salary $260 to start. 5 day week, pleasant living quarters. Write Peninsula Community Hospital, Box H-H, Carmel, Calif.

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PEDIATRIC SUPERVISOR: For accredited 330 bed general hospital, small school of nursing. New 32 bed pediatric unit will open February 1st. Salary open, 44 hr. week, 8 holidays, 4 weeks vacation, 12 days sick leave. Apply Director of Nursing, Perth Amboy General Hospital, Perth Amboy, N.J.

PUBLIC HEALTH: (a) P.H. supervisor, city hlth. dept., MW. (b) Staff nurses, city health dept. Duties include school nursing, car provided, college town Calif. RN3-9 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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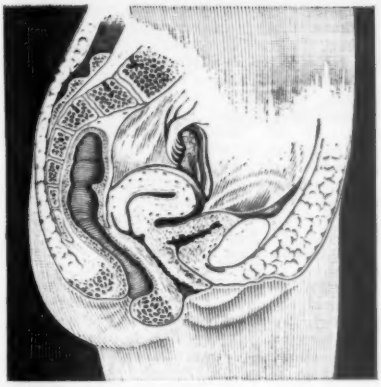

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STAFF NURSES: (a) Several, Med. center, group clinic, around $300. SW. (b) Several gen'l duty and surg., large hosp., outside U.S., mild climate. RN3-10 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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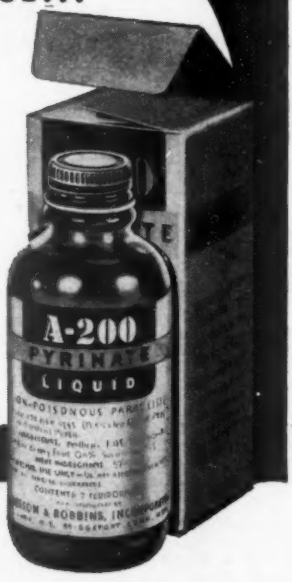

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STAFF NURSES: All shifts. Salaries: Days, $221.37 to $243.36; Evenings, $232.36 to $253; Two 3-11 Obstetrical nights, $237.86 to $258.50. Apply Fort Hamilton Hospital, Hamilton, Ohio.

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SUPERVISOR: Of Subsidiary workers in Nursing Service. Asst. Supervisor of Obstetrics with emphasis on teaching obstetrics to nursing students. Middlesex General Hospital, New Brunswick, N.J.

SUPERVISORS: (a) Clinical Supervisor. 200 bed hospital, western university city, world famous mountain resort. $3600. (b) Medical Floor. 300 bed New York teaching hospital, 40 hr. week, good salary. (c) Medical-Surgical. Degree required. $300 maintenance. East central location. (d) Obstetrical Teaching Supervisor. 300 bed teaching hospital, east coast resort city 80,000. Salary open, maintenance provided. (e) Operating Room. 250 bed general hospital, Illinois college town. $4200, maintenance. (f) Orthopedic Supervisor. 50 bed unit, large teaching hospital, Ohio city 30,000, excellent salary. (g) Pediatric Supervisor. 200 bed teaching hospital, northern California. $3700, 40 hr. week. (h) Psychiatric Supervisor. Large psychiatric hospital, lovely Shenandoah Valley. $3000 yearly. (i) Surgical Floor Supervisor. 200 bed Michigan teaching hospital. $3300. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

SUPERVISORS: (a) O.R. Min. 4 yrs. exp., modern well-equipped hosp., $6000, West Indies. (b) O.B. Leading hosp. univ. city outside U.S. (c) Orthopedic. Well-staffed dept., attrac. location, Calif. (d) O.B., new 225 bed hosp. college town, NW. $400-$450. (e) Ped. & Psy. New hosp. affil. med. school, univ. town, So. (f) O.R. Large tch'g. hosp. staff 16 nurses, 8 aides. $5000. (g) Clinic superv. 15 man group, NW. $4800. RN3-11 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SURGICAL NURSES: (a) Small industrial hospital, city 10,000 vicinity Phoenix, Arizona. $4200 minimum. (b) Large, modern hospital, 40 hr. week. $3000 maintenance. Los Angeles. (c) 50 bed modern hospital, western capital and mountain resort city. $2400, full maintenance. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

SURGICAL NURSES: (a) Gen'l hosp. Calif. seaport. $300. (b) Small hosp. resort town, No. $300, mtce. RN3-12 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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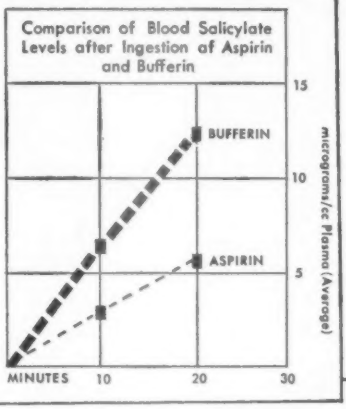

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1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950
2. Gastric Tolerance for Aspirin and Buffered Aspirin. Ind. Med. 20:480, Oct. 1951

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